Progress Through Partnership

Medicaid
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Management Institute

Eleventh Annual Conference of State Medicaid Directors

April 3-5, 1979

U.S. Department of Health,
Education, and Welfare
Health Care Financing Administration

11TH ANNUAL CONFERENCE
OF
STATE MEDICAID DIRECTORS

SAN DIEGO, CALIFORNIA

APRIL 3-5, 1979

Medicaid/Medicare Management Institute

Health Care Financing Administration
Department of Health, Education and Welfare

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PREFACE

The Eleventh Annual Conference of State Medicaid Directors included a wide range of priority areas in Medicaid management, both in plenary sessions and workshops. State Medicaid Directors, Regional Medicaid Directors and Medicaid Bureau Director, Richard Heim, held closed door meetings during the first day of the conference to allow frank discussion. The plenary session began on the second day with an update on national health insurance. During other plenary sessions, such important topics as MMIS, Medicare/Medicaid integration, EPSDT, fraud and abuse, cost containment, and the legislative perspective were discussed. During four sets of concurrent workshops presented by State and Federal participants, numerous other Medicaid management areas were discussed.

Approximately 300 people registered for the conference; however, at different times, over 500 were in attendance. Some 52 States and jurisdictions were represented. State agency staff played a far more active role in designing and participating in this conference than in previous ones. State staff assisted Federal staff in developing the agenda and participated in every panel. This trend will continue since more active involvement of State staff properly focuses the conference on State agency needs.

The State Directors' Council Report was presented at the conclusion of the conference and highlighted the directors' most pressing concerns and problems; it appears at the end of this report.

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JOHN LARREA, Contracting Officer, Medi-Cal Procurement Project

AL DOBSON, Director, Div. Beneficiary Studies, Office Policy, Planning and Research, HCFA

SECOND OPINION
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ROBERT SILVA, Assistant Director, Office of State Operations, Medicaid Bureau

BERNADETTE WHALEN, Director, Second Opinion Program, Mass. DPW

SUZANNE MARTIN, Project Director, Second Opinion Analysis, Mass. DPW

PATRICIA O'CONNOR, Administrator, Elective Surgical Opinion Program (PRESSO), N.Y. BC

DOUGLAS WILSON, Vice President, ABT Associates

UNIFORM BILLING AND DISCHARGE DATA
Uniform Hospital Reporting System for Billing & Discharge Data

KATHY HEADEN, Data Reporting Branch, Div. Analysis and Evaluation, Medicaid Bureau

STEPHEN PRESS, Director, Conn. Medical Care Administration

WILLIAM BARNETT, Florida MMIS Project, Systems Development Corp., Inc.

JAMES LEE, Director, Gov't. Systems, BC/BS Association

WILLIAM CRESSWELL, Chief, Hospital Reimbursement and Methodology Branch, Office Policy, Planning and Research, HCFA

CONTRACT NEGOTIATIONS AND CONTRACTOR PERFORMANCE
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J. PATRICK McCARTHY, Staff Director, State Contracts Staff, Medicaid Bureau

RICHARD J. CHERRIN, Administrator, Delaware Medical Services

WALTER CONWELL, Program Administrator, Florida Social and Economic Services, Medical Services

CONTRACT NEGOTIATIONS AND CONTRACTOR PERFORMANCE - Cont'd	PETER BLOOMSBURGH, Assistant Commissioner for Mass. Medical Services

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STATE PERSPECTIVE

Glenn Johnson, Chairman
State Medicaid Directors' Council

FEDERAL PERSPECTIVE

Richard W. Heim, Director
Medicaid Bureau
Health Care Financing Administration

MR. JOHNSON: Good morning, ladies and gentlemen. From the State perspective of the conference, I don't know whether we should consider this our interlude, since we have already had a good opening with our closed session yesterday, or the prelude. From our perspective, we feel that it may focus in two major areas, the first being the State-Federal communications. I think that, from our perspective, really, it is this interface between the State and the Federal people here that makes these meetings really beneficial.

We think that communication is probably a primary thing, and it is vital to the effective administration of the Medicaid program. Looking back over the past year, we feel there has been increased opportunity for contacts with all the various HCFA staff, and a reaching out, if you will, by HCFA people to seek advice from us. So we really feel that communication access is very vital, and I think this is just a continuation of this communication activity.

We get to know you, to identify you, and speak on a first-name basis, and we can then get on to the issues and our concerns.

Also, from our perspective, we think it has great value in interstate activities. This type of a forum is valuable in allowing us to come together, to have our State interchange. We are able here to talk, share our ideas, and find out what some of the proven methods are for this program, that we can take back with us.

So, yesterday, as usual, for those who don't know, we spent a long day on a schedule that we never completed, and the logs were rolling almost into the early evening. We will have a summary to share with you on Thursday.

So, we are pleased to have this session and this meeting, and we think that we are fortunate in having it in San Diego. It appears to be an ideal place both for a conference and for some celebration.

Thank you.

MR. HEIM: Good morning, ladies and gentlemen. I am indeed delighted to be here in San Diego with you. I recall last year, when I was in New Orleans with you, my impending appointment to be the head of the Medicaid Bureau was announced by the then Administrator of HCFA, Bob Derzon. I recall at the closing session making a comment that we really need to concentrate on working together and that I was going to emphasize my efforts to develop a better working relationship with the States.

Following my comments, many of you came up and wished me well in my new role, and gave me a grand send-off to Washington. Thirteen months later, the Administrator of the Health Care Financing Administration announced that the Medicaid Bureau will be abolished in June. So, I am appearing before you today as the last of a long line of Medicaid Directors and Commissioners of the Medical Services Administration.

I can't help but wonder whether there was a causal relationship between your wishing me well a year ago and sending me to Washington, and

the abolishment of the Bureau this year. I don't have the answer to that, but nevertheless, I am delighted to be with you again this year.

I personally think the reorganization of the Health Care Financing Administration will benefit all of us concerned with providing better service to our beneficiaries. As mentioned, Len Schaeffer, the Administrator of the Health Care Financing Administration, will be here on Thursday, and will discuss the reorganization in some detail.

Without stealing any of his thunder, let me say that he is very much concerned with some of your concerns that Medicaid not be "Medicarized," that Medicaid not be forced to conform to the Medicare mold.

To avoid this, an Office of Intergovernmental Affairs will be set up. This office will be the focal point for States and local governments in dealing with the Health Care Financing Administration, not just with Medicaid, but with all of the programs of HCFA that impinge on State operations.

Again, without trying to steal Len Schaeffer's thunder, he has asked me to take on this assignment, and I have happily accepted.

Without going into much more detail, I want to emphasize that the Medicaid program has, indeed, come a long way since its inception 13 years ago, but I am sure you will all agree with me that we still have a long way to go.

Some of you may have seen a Lou Harris poll, which was conducted last fall, which asked people to identify the 20 problems facing the United States today.

The first three problems listed were, in order, inflation, government spending, and the rise in health care costs. Now, obviously, these three problems are interconnected.

The Administration and Congress recognize these problems and are working hard to come up with legislation to address some of them, and particularly the problem of containing the health care costs. Whatever the final version, designing specific policies to deal with inflation in this sector of the economy is critically important.

Just focusing on hospital cost containment alone would be a significant step to hold down inflation. Between 1975 and 1977, hospital costs increased between 14 and 20 percent annually, more than twice the increase in the Consumer Price Index. This significant rise exceeds other highly inflationary elements in the economy.

During the same period, food prices increased between 3 and 8 percent, and fuel prices increased between 7 and 13 percent. In 1978, according to estimates based on hospital industry data, hospital expenses rose at an annual rate of 13.1 percent, and hospital room rates increased 12.4 percent, still much faster than food or fuel, or the Consumer Price Index, as a whole.

The average cost of hospital stays rose from $533 in 1969, to $1,634 in 1979, and is expected to reach $2,660 in 1984, given the present trends.

These increases in hospital costs have meant that expenditures for health care services grew from $60.3 billion in 1969, to $206 billion estimated in 1979; that they rose from 6.7 percent of Gross National Product in '69, to approximately 9.1 percent this year.

But last November's election results reflect something that is perhaps even more important, the mood of the American people at the end of the 1970s. And this mood, it seems to me, not only flails against high costs and high taxes, but also against a government that is perceived to be bloated, costly and mismanaged; in a word, a government that doesn't work.

Some commenters interpret this mood to also call for a turning back on the commitments this nation has made to the most vulnerable in our society, the poor, the sick, the aged, children, the handicapped, and those suffering from discrimination.

I cannot agree. I believe that the American people who, over the years, have demonstrated the most concern and the greatest generosity to the disadvantaged, both here in this country and in the rest of the world, will not turn their backs on the suffering and deprivation of our fellow human beings. I prefer, instead, to interpret the opinion polls and the elections as a warning and a challenge. To those of us, both elected and appointed to positions of public trust, to translate our citizens' wishes into practical reality, to make these social programs work or change them so that they can work; to stamp out fraud, abuse and waste, and to detect and punish those who rip off the system, whether they be recipients, providers, or government employees.

Secretary Califano, in a recent speech before the National Press Club, expressed this same feeling when he said, and I quote, "It was the challenge in the 1960s to enact long-delayed and much-needed social programs. It is the challenge of the 1970s to manage those programs well. Today as we come to close the '70s, our challenge is the challenge of austerity. We must match our compassion and generosity with competence and efficiency. Efficient management is, in itself, an act of compassion, for it unlocks resources to be used for human ends."

I think the message is clear. You and I, the Federal and State governments, have to demonstrate to the American people that we can manage, rather than be managed by, these big money programs such as Medicaid.

This is what this conference is all about. To bring you and me, representatives of State government, and representatives of the Federal government, together to discuss in great detail the problems that exist -- program problems, legislative problems, those things that we need to take back to our respective legislatures, whether the Congress or your State legislatures, for resolution.

It is a heavy agenda. There are some weighty items there for discussion. I think the agenda has been geared to address those issues that are very real and very important, maybe not all the issues that you would like to address, nor all the ones I would like to address, but they are key ones.

What this conference is all about is that you and I, the States and the Federal government, have to again seek ways of working better together; to demonstrate that we can, indeed, manage a very complex, very complicated, very politically sensitive program, in a way that the American people and their elected representatives can have greater confidence in it and in us.

Last year, in New Orleans, I indicated several areas that I thought we needed to work on jointly to improve this working relationship, so that we could better manage this very difficult program.

I listed as one of the things I was going to try to do, to the extent possible, was to involve States in the decision-making process.

I indicated a great need, on the Fed's part, to develop more realistic performance standards, that would put us in a position of evaluating and monitoring the States in terms of whether or not the objectives of the program were being met, rather than evaluating process.

I indicated to you my concern about our most significant management tool, the Medicaid Information System, which so few States had at that point developed systems. I expressed some concern about technical assistance and asked your cooperation in trying to identify those program areas in which the States both needed and wanted technical assistance.

I stressed communications, and said that we would try very hard to develop a better means of communicating with the States and not only with the State Medicaid agencies, but also with the umbrella agencies of State government, with governors and their staffs, and with State legislatures.

We haven't come as far as I wanted to come. I am sure we haven't come as far as any of you would have liked to come, but I think we did make some progress in each of these areas, and I would like to just touch on each of them very briefly.

The first item - involving States in the decision-making process. The staff of the Medicaid Bureau has had a number of meetings with your executive committee, in which we wrestled with this problem. We said it was one thing to say we wanted State input, and something else, indeed, to bring it about.

We developed a mechanism of notifying organizations representing State government that we were considering a policy issue, and invited these organizations to send representatives to meet with us in Washington at HEW's expense.

We have used this device on a number of occasions. We have found it a very productive way of getting good solid advice, of being able to test, with your perception of reality, the proposed changes that were being discussed.

For example, we called you together, or representatives of your organizations, to meet with us on the EPSDT penalty regulations, which were about to be published last September.

They still haven't been published, but they have been significantly changed, and have been significantly changed because of your input.

As we move along, we intend to use this device more frequently, and I think this will be focused through the new Office of Intergovernmental Affairs, and would appreciate your advice as to how to make this mechanism more effective. I know we have found it very worthwhile.

In the area of performance standards, it is very, very difficult to implement realistic performance standards and to get away from the very heavily process-oriented regulations that we use for managing the program today.

But, again, there has been some progress in the past year. Quality control is a program in which there are performance standards, in which a State will be measured on the results it can produce, in reducing eligibility errors, claims processing errors, and its success in accomplishing third party recoveries.

In the Administration's Child Health Assurance Program, which should be introduced soon in the Congress, changes the child health program from a very heavily-detailed process program, to a results-oriented program.

In MMIS, Medicaid Management Information Systems, a number of you were at the national meeting on MMIS, held in Albuquerque a couple of months ago, and heard Administrator Schaeffer, talk about some of the changes that were coming down the pike in the administration of MMIS.

I believe he will be emphasizing this again in his comments to you on Thursday, but very briefly, we are trying to move away from the heavy process requirements for certifying States and going to performance standards, geared toward the impact that an MMIS is having on the management of States' program.

Mr. Schaeffer announced at that meeting that we would be going the rulemaking route, to announce the criteria for recertifying or revalidating States which have been certified for MMIS, and the recertification will be geared toward the performance standards.

He also announced, however, that any system changes required to meet these new standards, would be paid for with 90 percent Federal funding for a State which owned its system.

He further made the commitment, because of the lead time necessary to make these changes, that every State would be given a reasonable period of time to effect any changes, or to correct deficiencies when they were noted, before a reduction in Federal financial participation would take place. He also promised that any changes in MMIS would be required no more often than once a year.

Technical assistance is another area that we discussed last year. It is one we are still groping at. In the past year, however, as some of the States are aware, a Corrective Action Project has been set up in the central office of HCFA to work with 10 States in developing corrective action programs regarding quality control.

Most States, as a result of several surveys conducted both by the Inspector General and by the Office of the Assistant Secretary for Management and Budget of HEW, have identified the Institute for Medicaid Management as a very positive force and an entity within HEW with which the States could identify.

We are delighted to have Mary Kenesson as the new head of the Institute for Medicaid Management, and we will be stressing, even more so in the future than in the past, the efforts in the Institute for Medicaid Management to serve as a broker for technical assistance, to identify best practices in States, and to disseminate this information through conferences and publications to the other States.

As a result of a request made by several State people to Undersecretary Hale Champion last year in New Orleans, an objective was set that the Regional Office, through the Principal Regional Official, the Regional HCFA Administrator, and the Regional Medicaid Director, would make visitations to States to talk to governors and key legislators, about the Medicaid program and to try to identify what some of the problem areas were. This effort was begun last summer, and will be continued this year.

As I think many of you know, I made a personal attempt in this past year to get around to each of the 10 Regional Offices. In all but a couple of the regions, we were able to set up a meeting with State Medicaid Directors and staff, in the Regional Office city.

I really appreciate your willingness to travel to your Regional Office city to meet with me. Many of these meetings were held on Saturday to make it possible for me to get around. I personally have found those meetings very helpful and productive. I didn't have many of the answers, but at least you alerted me to what some of the problems were, and we have been trying to address these.

In addition, I tried to honor the commitment I made to you a year ago to be responsive to you to the extent I could. I do try to get back to States that call me personally, and at your invitation, I have met with a number of you in your State capitals.

In my new role, I expect to continue this effort, not independently, but in conjunction with the Regional Office personnel. I have, in the past year, made personal visits to New York, California, Louisiana, South Carolina, Indiana, Illinois, and Wisconsin. In some of these visits, we were able to resolve some sticky issues right on the scene.

I think these are some of the positive things we have done to try to establish a better working relationship between you and the Federal government.

We have also had to take some actions, which many of you have found to be rather unpleasant and uncomfortable. I was alarmed when I arrived in Washington to find we had a big backlog of audit reports and of unresolved disallowances.

Our financial management staff in the Central Office, working with the Regional Office staffs, have been trying to clear up this backlog as rapidly as possible. Many of you have received disallowance letters either signed by me, or reconsideration actions signed by the Administrator.

We still have a few to go. So, I am putting you on notice that more of these letters are going to be arriving. We do need to clean up this backlog. We are being held accountable. As you all are aware, you do have the right, and we encourage you to exercise this right, if you do not agree with the findings, to take an appeal to the Departmental Grants Appeal Board.

Let me just make this comment on abortion and sterilization. We have bothered you on both these programs. It seems we are spending an awful lot of time and effort on abortions and sterilizations. Let me just remind you, regardless of your personal views, our role is to carry out the wishes of Congress. This is a very politically sensitive issue.

We must ask you, in your reporting, to be as accurate as possible, because we are forced to audit you in both of these program areas extensively. These audits are being conducted both by our own staff, by Program Integrity staff, and by the Office of the Inspector General. It

does not make either you or us look good when the numbers you report do not agree with the audits.

Again, I am glad to see you all here. I know I am awfully happy tc be here. I hope we have a good conference, and get a lot of business taken care of, but I hope we also have some fun, too. This is a great place to be.

NATIONAL HEALTH INSURANCE, AN UPDATE

James Mongan, M.D.
Deputy Assistant Secretary
for Health/National Health Insurance
Department of Health, Education and Welfare

DR. MONGAN: What I would like to do here this morning is to spend 20 or 25 minutes trying to chat a little bit in an attempt to bring some clarity to the relatively confused state of reporting about the national health insurance situation.

I would like to talk first, for a few minutes, about the process we have been involved in, in putting a bill together; then, talk for a few minutes about the substance of the issue, go on and talk for a few minutes about some of the political issues surrounding NHI, and conclude with a few remarks about how this all may impact those of you in this room who have real interest in the current Medicaid program.

During the first year and a half of the Administration, most of the activities with respect to national health insurance fell into two categories. First, an Advisory Committee was appointed early in the administration, composed of 33 distinguished citizens representing all facets of the debate on national health insurance.

They met and deliberated for about a year or so, working with us, so that we could get the views of that kind of cross-section of experts on a variety of the subissues involved in the health insurance debate.

There was also a good deal of staff work done during that year and a half. First was a general analysis of the kinds of issues, reimbursement, administration, et cetera, that must be dealt with in putting together a plan. And, secondly, we began to put together three or four prototype national health insurance plans for the Advisory Committee to consider and for the ranking officials of the Department to consider.

In April, a lead agency memorandum was prepared for members of a Cabinet-level committee, who had been appointed to further study this issue in terms of its impact upon the various Cabinet departments.

All of that activity led up last July to the President's statement of principles on a national health plan. I won't go through each of those principles in detail here this morning, but I would just stress that three of them were of some special significance.

The first of these was the President's clear indication that ultimately he favored a universal comprehensive national health insurance plan for this country.

A second critical principle was that that plan should ultimately be based upon a mixed public-private system, rather than being an entirely public or an entirely private plan.

And the third very significant of those principles last July was the President's great stress upon the fact that any national health plan had to be very carefully phased into effect, both because of the large size and importance of the health care sector in this country, but also because of the very serious problems we had with the implementation of the Medicare and Medicaid programs over the past decade. The President felt very strongly that any health plan must be phased into effect very carefully.

Now, at the same time that the President released these principles for a national health plan in July, he accompanied them with a directive to the Secretary of HEW to develop a tentative plan as the next step in the national health process.

That plan was due at the White House by the end of the year. There was a little bit of slippage in our meeting that timetable, but we did put together a document, which has since leaked widely, and may have been read by many of you, called the "HEW Draft Tentative Plan for a National Health Program."

We presented that plan to the President at the White House in mid-January. The President, at that meeting, instructed us that prior to disseminating that plan broadly throughout the country for discussion and consultation before turning it into a legislative document, we should have a series of discussions with the leadership on Capitol Hill and leaders of a few concerned interest groups such as governors, American Hospital Association, AMA, other levels of government, State and local government, legislative leaders, along with executive branch leaders.

We had a series of discussions from late January through the end of February, focused really on two issues. We asked the Congressional leaders, and the others we discussed this issue with, what their general reaction was to the draft tentative plan and, more importantly, what their views were with respect to phasing such a plan into effect, which kinds of coverage should be included in the first phase, how long should that phase stay in effect, et cetera.

After that period of consultation, near the end of February, we went back for further discussions with the President. And about two weeks ago, the President made a decision, which was given fairly broad attention in the press. The gist of the decision was that he would go forward this year with legislation only to implement the first phase of a plan, and that he would not go forth with legislation to set out the entire national health plan and to have it automatically go into effect.

Basically, the overwhelming sentiment from the consultations we had, particularly with the Congressional leadership, was that the Congress could not pass a broad national health insurance bill during this session, and that the most the Congress would be able to deal with would be a first phase.

This fit in with the President's thinking that we should go very carefully in this area in any event. So, what the Secretary announced two weeks ago was that we would be sending to the Congress in the relatively near future, legislation dealing with the first phase of a national health plan, accompanied by a white paper which would describe, in some detail, the administration's views with respect to what an ultimately full-implemented plan should look like.

Having talked with you a moment about the process that has led up to the present time, let me talk a bit about the substance of both the tentative plan, which had been outlined in January, and of the first

phase, which was announced within the past few weeks.

The tentative plan, which HEW had submitted to the White House, was a plan which ultimately would provide universal comprehensive coverage. As I indicated earlier, it was based upon a mixed public-private system under which employers would be required to offer their full-time employees health insurance coverage.

Such coverage could be obtained through the private sector, or if the employer so chose, through a public program. The public program, in addition to providing optional coverage for employees, would also cover the aged, the disabled, low-income, and many of the singles and part-time employed people, who would otherwise be unable to obtain private coverage.

Now, in order to deal with the problem posed by a mixed public-private system, the problem of the private system getting the better risks and succeeding at the expense of the deterioration of the public program, we had built in a series of devices.

First, and perhaps most important, benefits would have to be the same under all of the private and the public plans. The floor level of benefits would be the same. More significantly, the reimbursement would have to be the same. We would be talking about a system of reimbursement to hospitals and physicians, where both the public and the private plans would ultimately pay the same amount to the providers.

So, the tentative plan called for a universal comprehensive plan based on a mixed public-private system. Encompassed within that plan was a system of phasing by which we would phase that plan into effect over an 8 to 10 year period.

Now, the phasing system was a little more complex than most people had talked about in the past. In the past, most discussions of phasing had centered on either starting with all poor people, or starting with all children, or starting with catastrophic benefits.

We chose a mixed system of phasing under which all groups of the population would get some benefits from the beginning of the phasing schedule, and the benefits would be increased over time until we ultimately got to the universal comprehensive plan.

For example, with respect to the aged, their benefit structure would be aligned. For example, a limitation on hospital days would be removed, and limits would be placed on their out-of-pocket payments under Medicare.

With respect to the employed, this was one of the more important issues we faced in dealing with phasing. The concern about the employed population had been that if you put a large burden on the employer immediately, you might cause some very serious economic problems in those industries where health insurance is currently not very widespread.

In order to deal with that, the phasing schedule said that in the early years, their protection would have to meet a series of standards in terms of the kind of pre-existing condition limitations, et cetera, which cause so many problems with private coverage today. But that in the earliest phases, the policy could carry a large deductible, so that the cost of the premium would not be as high in the early years.

As the plan moved toward full implementation, the deductible would drop to the point that we would no longer have a deductible and only a standard cost-sharing package of 25 percent on all services up to a $1,500 family max.

But, basically, we would phase in on the employer by starting with a relatively small burden on the employer, and expanding it out until he had to provide a comprehensive package.

Now, the other important issue in phasing had to do with the low-income population, and, of course, the reason that is important is because the largest Federal budget burden of any of these health insurance plans comes from the cost of subsidizing those millions of low-income citizens, who are not currently covered under the Medicaid program.

Now, in order to avoid all of that budgetary impact coming in the first phase, we put together a similar sort of structure in which all poor children would be brought into coverage in the first phase, and then the poorest of the poor, up to some arbitrary percent of the poverty line in the second phase, moving up until, in the final phase, all people below the poverty level were covered by the program.

To recap briefly, the tentative plan called for ultimately phasing in a universal comprehensive program, based on a mixed public-private system, with the phasing mechanism being a mixed mechanism which added benefits for all groups over time.

Having described the program outlined in the tentative plan, let me turn for just a few minutes to a description of the first phase, as it is set out thus far. I think what I will do at this point, for four or five minutes, is to read to you from some testimony delivered by the Secretary before the Senate Finance Committee last week.

I am doing that because this testimony at the moment represents the definitive statement upon which the White House, OMB, HEW, et cetera, could agree, and I will be certain, when I read this, that I will not misspeak with respect to the current plans for the first phase of a national health plan.

The overall structure of the first phase will have three major components. First, coverage of full-time employed individuals and their families will be predicated upon mandated employer coverage, that will effectively require most, and possibly all, employers to provide private insurance that has a core level of protection and meets other basic standards.

Second, publicly-financed health care programs will provide coverage for the aged and the poor. To the greatest extent possible, we will seek to integrate, to make uniform, and to make increasingly efficient, program administration and reimbursement systems in these public programs. For example, serious administrative difficulties exist in Medicaid because of the fact that we have 53 different programs, not a single program.

Third, for those not protected by employer coverage, or by the public programs for the poor and the aged, the Federal government will guarantee the opportunity to buy health insurance at a reasonable rate.

In the Phase I bill, this Federal guarantee will provide the opportunity to purchase more affordable quality protection against the cost of major illness. At present, such an opportunity for coverage does not exist for millions of non-poor, non-aged, non-employed Americans.

The first phase will affect the various groups in the population, as follows: the aged and disabled. The Phase I bill will obviously continue to provide the benefits offered under the current Medicare program, and will also include additional protection for our elderly and disabled citizens. We must especially insure that our elderly citizens are not devastated by the costs of major illness. We will also consider making more accessible to the elderly, methods of therapy that could reduce the need for extended hospitalization.

The poor: the Phase I bill would significantly expand the number of America's poor who would be covered fully for their medical expenses. The plan would expand coverage, in part, by setting eligibility for millions of our poor at uniform income levels nationwide, thus remedying the striking interstate inequities that exist in the present Medicaid program.

The employed: as indicated above, the Phase I bill will establish mandatory standards for private insurance coverage provided by employers. These standards could include quality requirements, a core benefit package, and extension of coverage for a certain period beyond termination of employment.

The Phase I bill will mandate that qualified employer plans protect families against major expenses by limiting their financial obligation to a reasonable ceiling in a given year.

This financial protection could be expanded in subsequent years. In addition, the plan may mandate that employers maintain their current financial contributions per employee for health insurance coverage. We will look carefully at the impact these requirements have on business, especially on small and low-wage firms.

All others: for those who are not employed, and who are not otherwise covered through the provisions for the aged and the poor, or

through other private insurance, the Phase I bill would, as noted, seek to make quality coverage against major illness more affordable.

Thus, health coverage that puts a ceiling on the direct health costs, that must be borne in any year, will be universally available.

Finally, and of critical importance, the plan would include a series of cost containment and delivery system reform provisions. The hospital provisions will build upon the President's hospital cost containment bill, which was introduced earlier this year.

We will also be considering provisions to reform our current open-ended mechanisms of physician reimbursement. The system reform provisions will, as noted, also build on a number of important ongoing administration efforts, such as the encouragement of Health Maintenance Organizations, limitations on capital expenditures, and provisions aimed at assessing the appropriateness of new technological advances in the health care area.

In a few weeks, we will send forth legislation to the Congress containing these provisions.

Cost sharing: the Phase I bill will involve cost sharing for all but the poor. As noted, a reasonable ceiling will, however, be placed on the amount any family or individual would be required to pay for direct medical expense in any year.

Federal financing: there will be no payroll tax increases required by the Phase I bill. Additional Federal expenditures will be financed by general revenues.

In summary, then, the proposal for the first phase of a national health program will contain provisions aimed at improving coverage from the outset for all groups in the population, and putting in place necessary cost control and system reform provisions.

Having talked for a moment about the tentative plan and about the first phase of the plan, let me just spend a few minutes on the politics of the situation.

It is obvious that there have been a number of people on Captiol Hill interested in this issue. And on the Senate side, where the debate seems to be getting into gear first, there seem to be at least two major counterproposals.

One, of course, is represented by Senator Kennedy. Senator Kennedy, back last fall, changed his long-standing position in support of the health security bill, and has had his staff, working together with labor representatives, putting together a new version of their proposal, a version, which they announced in the fall, would be more dependent upon private insurance coverage than had been the health security proposal. We have not seen a final version of Senator Kennedy's new proposal yet, so I am not really in a position this

morning to tell you with any kind of clear distinction about the major similarities or differences between his proposal and ours.

I think generically I can touch upon three or four differences, which I think we can project from their statements over recent weeks.

With respect to financing, our proposal ultimately would be based upon premium financing by the employer and the employee. Senator Kennedy was talking last fall about what he called "an earnings-related premium," as a means of financing the program.

There may well be a difference with respect to the role of the insurers. Our program will call for a much greater degree of regulation of the insurers, the benefit package they can offer, the reimbursement mechanisms they must use.

Senator Kennedy's statements last fall seemed to indicate that they were going to talk about putting all private insurers into a consortia within each State, and that consortia would then deal with the Federal government. Again, there is not enough detail at the present to outline for you the specific differences between those consortia and the current role of the insurance industry.

And, finally, with respect to cost sharing, Senator Kennedy and the labor movement have always felt there should be first-dollar coverage without any cost sharing. The administration has indicated that we will have cost sharing: 25 percent of all services up to a family maximum of $1,500 were the figures tentatively discussed.

Now, the other major proposition on the Senate side is the Long-Ribicoff proposal, which the Chairman and other members of the Finance Committee have introduced during recent Congresses. I could spend just a moment touching upon the most important differences between Long-Ribicoff and the Administration's first phase proposition.

I think one of the key differences -- and a difference which is far more than just rhetorical, because of the impact it may have on the way you structure your first phase -- is that, although there are similarities between the first phase of the Administration's proposal and the Long-Ribicoff proposal, Senators Long and Ribicoff have often advertised their proposal as all we should do now, as a first step, but without any other steps necessarily following. In other words, if private insurance coverage increased and that bill were passed, they might not necessarily see any further reason to proceed.

The President views our first phase very much as a first step as opposed to a total solution. Now, as I indicated, I think that will well turn out to be, over coming months, more than just a rhetorical difference, because if you do have your eye on eventually expanding a program, you are apt to put some provisions into that proposal, which may look considerably different than proposals you would put in if you viewed a smaller approach, as just the only piece of legislation you would be apt to pass during the next decade.

In addition to that important difference between the Administration's first phase and Long-Ribicoff, there are two others worthy of note. Senator Long has introduced two bills, one his broader catastrophic, Federalized Medicaid, standards for insurance bill.

He has also introduced a catastrophic only bill. The Administration made it very clear, in testimony before the Finance Committee, that we are very concerned with, and would oppose, a catastrophic only measure unless it were linked with the necessary controls and with necessary expansion of coverage for the low-income population, to increase the equity that would not be provided by a catastrophic only proposal.

One other difference is that the standards for private insurance, outlined in the Long-Ribicoff bill, are voluntary standards only. If the insurer met them, he could receive a government seal, whereas, under the Adminstration's thinking, those standards would be mandatory, enforced either through the tax code or as a condition of the employer purchasing the policy.

Having spent just a minute on outlining some of the differences between the Administration, Senator Kennedy, and Senator Long, let me just dwell for a moment on what the chances for action might be.

I think if you had asked anybody in Washington up to a few weeks ago, the general view was that there was a very slim chance that Congress, in this current era, would be involved with a major new social program in this session.

I think that that has changed somewhat over the past weeks, with the President now asking for just the first step, rather than the whole bill, with that first step bearing some important similarities to what Senator Long and Ribicoff have been asking for, and with Senator Kennedy's recent movement on the issue.

I think there is at this point, at least, a distinct possibility that the Congress may, in fact, get very deeply into this issue this year, and that we may have the substrata present for the kind of compromise which is necessary to put together a piece of legislation which can pass both Houses of Congress.

In concluding, let me just say a few remarks about the potential impact of all of this on this group today.

You all are people who are currently administering the Medicaid program within the 53 jurisdictions, and I think it is obvious that people in this room would have, and should have, concerns about the role of the State under any national health plan.

Because of the tentative nature of all of these decisions and because of the fact that the details of our first phase plan are not fleshed out beyond what I read you, I am not in a position to make any definitive statements about the role of the State either under our

finally-envisioned plan or under the first step. But I think I can indicate some directions of thinking. As far as the final plan was concerned, the tentative plan that had been discussed in January, there were a few very important State roles contained within that plan.

The basic plan called for a uniform Federally-administered program, the public program labeled "health care," which would, in part, replace the Medicaid program.

That program would be, as I indicated, Federally operated, and Federal direction would be paramount with respect to reimbursement benefits, eligibility, et cetera. Remaining State roles would be, as follows: none of the national health plans to date have included coverage of long term care. So, under any of the national health plans currently being considered or discussed by the Congress, long term care would remain as a residual Medicaid program with continued Federal-State matching.

In addition to the long term care program, State functions in licensure would continue, current State functions in insurance regulation would continue, and current State functions with respect to planning would continue.

With respect to the first phase of the plan, I must tell you there is a good deal of tension within the discussions, not only within the Department, but also within the administration, as a whole, and I am certain it will be repeated on Capitol Hill. Basically, there are a series of things which drive people towards wanting a greater Federal role, and a series of factors which drive people towards wanting to continue with, or even strengthen, the current State role.

Obviously, on the side of a continued or strengthened State role is the attractiveness of capturing the current State financing in some way. Secondly, there is the attraction of building on a current administrative structure. After all, we do have Medicaid programs in place. They are being administered. And that structure is there to build upon.

I think a third factor driving towards a greater State role is the fact that it could lead towards the whole program benefiting from some innovative efforts, which might be undertaken in one or another State.

On the other side of the coin, there are factors which push towards a greater Federal role, one of those being greater countrywide equity; in other words, evening the benefit package, evening eligibility, and evening the administrative rules used in making the benefit and eligibility judgments. Another factor on that side of the coin is the feeling among some that we could get more efficient administration if we had one program, rather than 53 different programs.

In sum, then, I can't give you a strong consensus view that the first phase will involve either a greater State role than under the current Medicaid program, or a reduced State role than you have under

the current Medicaid program. About the best I am in a position to do this morning is to outline to you the factors, which I just mentioned, which are weighing in the balance in that debate. But I think within the next four to six weeks, we will have some preliminary judgements on the Administration's part about the nature of this balance.

And I am certain that at that time, we will have some extensive consultations with the governors, with the State human resources directors, and with people from the Medicaid program, before locking ourselves into any specific view on that matter.

I appreciate the opportunity to join you here this morning, and I hope I have added a little clarity rather than further confusing the issue.

Thank you very much for your attention.

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QUESTION: What is the relationship between what you were just talking about and the other Federal programs, VA, Champus, and things of this type?

DR. MONGAN: That is a very good question. I am certain there is somewhere a reporter for the VA or Armed Services Time in the room, because every time I say anything about the VA, it appears in the Armed Services Journal, as "HEW has designs on the VA system." In actuality, what we have talked about with respect to the tentative plan that had been issued a few months back, was the following -- and it was a balance, which the VA and Defense seemed, in general, to agree with, although I think they had some additional points of their own they would like to see.

Basically, we would continue, in large part, with a separate Defense Department system. They, obviously, have special needs both overseas and in certain areas here at home. So, we are not talking about dismantling either the Defense Department or the VA system.

But with respect to the population who is covered, which would be the majority of people eligible for VA coverage, certainly, and many of the people eligible as dependents for Defense coverage, we are saying that the national health plan ultimately will make reimbursement for those people to those facilities.

In other words, the VA and Defense Department facilities would be integrated within the national health program, although they would retain their special and separate stature as direct government providers.

Now, obviously, they would like to see, I think, both maintaining their annual appropriation, receiving funds from the national health plan, and then perhaps offsetting it against their appropriation. I am not certain how the Congress will ultimately work that out, but their

financing will presumably be a mixture of funds received from the national health plan plus funds received from their regular appropriation. In summary, they will be continued as separate systems, but they will be integrated with the financing mechanisms and the other kinds of provisions and conditions laid out in the national health plan.

MR. HEIM: Jim, one of the questions, which has been directed at me, about a national health insurance program, relates to long term care, which you addressed and said that this would be a residual program if Medicaid is Federalized, but this will continue to be a State-administered program jointly funded by the Federal and State governments. Some of the comments that have been directed to me is that if you are going to Federalize Medicaid, why don't you take long term care, as well, since that is one of the toughest programs, if not to administer, at least to finance? It is growing every year. It is presently constituting about 40 percent, on a national average, of all Medicaid expenditures. In some States, it runs as high as 65 percent.

Can you share with us some of the deliberations that have led to the conclusions that you shared with us?

DR. MONGAN: Yes, two things. First off, I very carefully didn't use the term "Federalized Medicaid" at any point during this conversation. One, I am not quite sure what the term "Federalized Medicaid" means anymore. Does it mean Federalized administration in State dollars, or does it mean State administration in Federalized dollars, or both of them being Federal, and I am not sure it is very clear.

Secondly, as I indicated towards the conclusion of my remarks, I think the debate is open enough with respect to the relative role of the States vis-a-vis the Federal government in the early phases, that I am not at all certain it is going to go in the direction of Federalized Medicaid. I think that is a very open question.

But I did indicate rather clearly that long term care would be dealt with on a separate track. Basically, there are two reasons for that. As I indicated, there is not a single health insurance bill, which has been introduced in the Congress, ranging from the Kennedy and Dellums' bill on one end of the extreme, all the way through the catastrophic only proposals, and including the AHA and AMA bills, that has proposed to cover long term care.

There are two reasons for this, one perhaps more legitimate than the other. The first reason is people are scared of the financial impact. As you just mentioned here, it is a large and a growing part. It is a financial burden which the Federal government and the States currently share. Nobody is talking about dumping a greater amount of it on the States. At the worst, if you will, we would continue with the present sharing arrangements. But there is some real concern about the financial impact of taking it over 100 percent lock, stock, and barrel.

In a way, a more important concern, but a concern which I am all too well aware has been used as kind of an excuse or a justification in

the past, is the concern about whether or not it is appropriate to deal with long term care in the context of a health insurance-related program, or whether it doesn't make more sense to start from the viewpoint that long term care is basically or ought, basically, to be a program discussed in the context of the overall social needs of the declining elderly population.

Now, as I say, I am aware that has been used as a kind of a cop-out in the past, that, "Oh, well, we don't want to make this part of the health care system anyway, and, therefore, we don't have to pay for it."

I really am not putting it forth here this morning in that context, but rather putting it forth in the context that, in fact, it could be a way to make long term care very much more expensive if we continue to structure everything to the kind of medical model, with the kind of nursing overlay and other medical overlay that you get in that way, or whether it is more appropriate, on the other hand, to start with the long term care program, more closely linked to the social needs of the elderly.

I would be the first to say that puts a burden upon us to, in fact, put out our views and our ideas with respect to what that companion long term care program would look like. I fully expect that the Department will turn its attention towards doing that as soon as we get this piece of legislation packaged up.

As I say, at the worst, we are not talking about turning and running and leaving long term care with the States. At the worst, we are talking about maintaining the status quo for a short period while we try and put together some reasonable proposition for dealing with long term care in its own special context.

DR. PESARE: Dr. Mongan, I am Dr. Pesare from Rhode Island. Some five or six years ago, we had the pleasure of having Senator Kennedy visit us in Rhode Island. At that time, naturally, his subject was health care, national health care.

His opening statement was to this effect. If Medicare is good enough for 20 million people in this nation, then, certainly, it should be good enough for the entire nation. Now, what I would like to know is, five years later, how do you feel about Medicare in terms of how effective and how good it has been? How much of the Medicare concept has been retained, or is intended to be retained, within the concepts of national health insurance plans, as you discussed them?

DR. MONGAN: Well, let me start with a cliche. We would like to retain its strengths and junk its weaknesses. I think it has both. I think Senator Kennedy feels it has both, and I know President Carter feels it has both.

The kinds of strengths we would like to maintain are the fact that each individual, as they now do if they are over 65, is guaranteed a

certain floor level of protection. They have it as a matter of right, if you will, associated with the employment they have been involved in throughout their lives. And we would like to see the kind of steps, I think we have made, towards having a fairly uniform administrative mechanism for a program, so that people from one part of the country to the other part know they have a certain level of protection available to them.

On the other hand, I think there is a general concensus that the Medicare program has some weaknesses. I think there is concern about the kinds of reimbursement mechanisms, which were built into those programs at their start in 1965, concerned basically as to whether that reasonable cost and reasonable charge reimbursement wasn't too open-ended. I don't think there are any of us involved in the debate who want to just grandfather everybody into Medicare without any kind of change in those reimbursement mechanisms.

Although I talked about how Medicare has given us a certain floor level of administrative equity throughout the country, in fact, there are still some fairly striking differences between what one carrier will allow in one area, and another carrier will allow in another. So that I think we are concerned about further improvements in the administration.

But I think, in summary, we would like to see, as a general rule, the kind of floor level of protection available to everybody in the population. I think the most important thing we would like to change is the kind of reimbursement mechanisms embodied within the Medicare program.

MS. MARTIN: I am Suzanne Martin from Massachusetts. Could you tell me what you expect, under Phase I, to be the shift in the sources of funding, both between the State and Federal share, and under the private funding, between insurers and out-of-pocket expenditures?

DR. MONGAN: The shift in funding? I did leave out one important point. I cannot give you X point X billion dollars for each source before and after, because we obviously don't have that degree of detail yet. I can tell you a few important trends you will see in the Phase I. The most important one is there will be an increase in Federal general revenue spending, and the figure used by the President was that he would be willing to invest an additional $10 billion to $15 billion in the Phase I proposal.

So, you will see an increase from $10 billion to $15 billion in Federal expenditures. You will see probably an increase of a smaller magnitude, although, I can't tell you the exact number, but definitely of a smaller magnitude in additional employer expenditures. We have not made final decisions on State expenditures. I think when we are talking about a more restricted first step of this sort, we are obviously not talking about having a large amount of money available for fiscal relief for the States. At the same time, we are clearly not going to be

talking about demanding greater expenditures. So, I would think you would see about a constant level of State expenditures.

So, to recap the four sources, an increase of from $10 billion to $15 billion in Federal expenditures, a steady level in State expenditures, a slight increase in employer expenditures, and with a consequent decrease in out-of-pocket expenditures.

MR. CARR: Dr. Mongan, I am Tim Carr from the National Institute of Mental Health. I noted that you mentioned whom will be covered under the national health insurance program, but other than mentioning a service mix, there was no elaboration on what kinds of services these people would be provided with under Phase I. Would you care to elaborate on that?

DR. MONGAN: Yes. Excuse me for trying to condense things too much and leaving out some important points. The benefit package that we had talked about in the tentative plan when fully implemented, was a benefit package of all hospital, physician, laboratory, and X-ray services; a benefit package which would include preventive services under a schedule similar to that outlined by the Institute of Medicine, not yearly physicals, but regular examinations on a scheduled basis, more frequently in the early and later years of life, less frequently in the middle years; and a mental health benefit package. Tentatively, we had talked about some limitations, 30 days on the inpatient side, $1,000 on the outpatient side, although those limits were quite tentative.

So, therefore, what you had a package of was acute care services, hospital, physician, laboratory, X-ray; mental health with some limitations; and a preventive package with some limitations.

The first phase package would be that package for low-income, aged, et cetera, people, who were fully covered from the first phase on. For some of those groups in the employed population, who don't have better coverage now, they may get that package, but with some significant cost sharing in the form of deductibles in the early phase.

QUESTION: What seems to be missing, is in reference to pharmaceutical services. The Medicare program, at the present time, basically provides no coverage for pharmaceutical services in the ambulatory sector. I am wondering how this particular area is going to be addressed in Phase I.

DR. MONGAN: I am sorry, I misspoke again. The administrative task of putting together a nationwide drugs coverage program, with the millions of pieces of paper and claims that are involved, seemed to be substantial enough that it was the better part of valor to try and phase in that kind of a complex benefit towards the end of the phasing schedule. I rather think that will hold in our Phase I discussions, which means that it will not be a part of the core benefit package. But, of course, to the extent we already cover it under Medicaid, it would continue with continued matching in that instance.

QUESTION: Has there been any attempt to define the poor a little bit more carefully? It seems to me that one of the problems in things like Proposition 13 is that middle-class people kind of feel that they are supporting a lot of people that really shouldn't be eligible. When we tie everything to the means tests, it turns out that we have people in nursing homes on Medicaid because we can't afford to pay for it anymore. I wonder if there isn't some way of tightening up what is really poor and making sure that people are getting benefits who need them and have really no other alternative.

DR. MONGAN: It is, as you know, a very difficult problem, and we have done a number of things. Let me tell you our tentative thinking and then some of the kinds of issues that kind of remain. We are talking about trying to move towards a uniform definition. We are talking about breaking the categorical link, so that we would include working poor along with welfare-type families, so that we would include singles and childless couples.

The ultimate plan called for covering all people below whatever income standard was chosen. The standard, that we had used in tentative discussion, was about 10 percent below the poverty level, and when you combine it with food stamps, it would be covering everybody up to the rough equivalent of the poverty level. Obviously, you get into some issues about what the relative income for four-person versus two-person versus one-person families ought to be. There are all sorts of wizards, who seem to work on those kinds of issues. I am not sure they come up with very good answers. But what we are talking about thus far is a level based on about the poverty standard when you add in food stamps.

One of the other important issues is the issue of whether it ought to be uniform nationally, or whether it ought to reflect, in some fashion, costs of living in an area. Generally, the sentiment is to make it uniform Federally, although there are minority views on that, I should say, within the Administration.

The other very difficult issue, and I think the issue that leads to some of the kinds of stories about deserving versus non-deserving, are these kind of disregard issues and how many disregards we would allow, how high total income you could get and still maintain benefits. Obviously, that gets all very entwined with are you going to make anybody worse off, people who are already covered, are they going to lose coverage because they are at a higher income standard, et cetera, and I can't tell you that I have a final answer with respect to the first phase.

There seems to be some strong sentiment for not having a bill which harms people, namely, having some grandfather provisions, and for trying to get to a more uniform floor rather than having all the kinds of peaks and valleys, which the disregards seem to build in from State to State.

MR. PRESS: I am Steve Press, Medicaid Director from Connecticut. You indicated a probable constant level of expenditures for the States under Phase I. Does this take into account the fact that long term care

is going to remain with the States?

DR. MONGAN: Yes. Again, I may be using important words too loosely. By "constant," I mean continuation of whatever the present trend is. I didn't mean capping necessarily. But, yes, it does include long term care, because, as I indicated, we are not talking about changing the funding with respect to long term care. So, basically, under current thinking, whatever happens with respect to the rest of this stuff, long term care will remain, as it does today, namely, increasing, increasing on both the State and the Federal government.

MMIS STATUS AND PLANS

Joint Report:

Richard Friedman, Special Assistant
to the Director Medicaid Bureau

Howard Stansberry, Medical Services Assistant
Oklahoma Department of Institutions

Robert Silva, Assistant Director
Office of State Operations
Medicaid Bureau

Robert Nakamoto, Deputy Assistant Director
Office of State Operations
Medicaid Bureau

MR. FRIEDMAN: In terms of an overview of the MMIS Task Force, I would like to start with the organization, and that is specifically with the Steering Committee that was appointed by Len Schaeffer.

Dick Heim is the Chair of it, as is indicated here, with the Medicaid position. The National Technical Advisory Group, consisting of representatives from eight States, primarily with the systems' background, will be advising Medicaid on a number of issues, but one of them in this context is in regard to the Task Force. This will be discussed later by the other panel members.

In terms of State representation, Paul Allen, the Medicaid Director from the great State of Michigan, is the representative. As far as regional input to the Steering Committee, Dick Morris, from Atlanta, is the representative.

From the Office of the Secretary, David Taylor is the representative. From the Inspector General's Office, it is the Deputy Inspector General, Brian Mitchell. And then on the HCFA side of the chart here, from Medicare, is the Deputy Administrator, Lamont Williamson. Health Standards and Quality Bureau, is Dan Nickelson. For Program Integrity, it is the Director, Don Nicholson. And there is staff representation from HCFA's OPPR and OMB on the Steering Committee, as well.

The Steering Committee meets about every three weeks, and there is a small staff of about five people that work on a number of issues during the course of the interim periods to develop position papers for the Steering Committee. In addition, the National Technical Advisory Group, is simultaneously working on a number of issues, and presents their position through representatives on the Steering Committee periodically.

As Dick mentioned, the purpose of this Task Force, that is to conclude at the end of June, is ambitious. It is to evaluate the existing MMIS and recommend specific action steps, both administrative, legislative, and statutory, that can be used to reorient MMIS from an internal process orientation, associated with automatic claims payment, to performance standards, and try to turn it into a true management control system. It is an ambitious goal.

There are five specific goals that have been agreed upon for the Task Force. The overriding goal is the establishment of performance standards. What we have in mind there specifically is to identify the current weaknesses in MMIS, which prevent it from serving as true management control system, which is capable of measuring the gap between program performance and program goals, and to develop some performance standards specifically in the areas of reporting systems, claims processing, cross-referencing of cases for peer review, as well as the area of fraud, abuse and waste. Those are at least four areas that we are working on to develop performance standards. There will be others, I am sure, as we get further into it.

The second goal is to establish effective interfaces between MMIS

and the various units concerned with fraud, abuse and waste. Specifically, the Steering Committee is seeking to identify specific action steps needed to improve the effectiveness of SURS and MARS modules, to ensure that there is sufficient input from the various user groups such as PSROs and others, to effectively improve MMIS on the front end, as well as to evaluate how effectively the fraud, abuse and waste staffs are able to use the system outputs: what is the capability, what are some of their problems as it is presently constituted, what have the results been in the past in specific States, and how well is the relationship between such units as PSROs and other users working, what needs to be done to improve this relationship, and what is within the bailiwick of MMIS that they can cope with that problem, because it is so large.

The third goal is to ensure that the necessary steps required to establish an effective working relationship between the various HEW components involved with the Medicaid program are identified and acted upon.

This specifically addresses the issues of problems which exist with the present relationship between Titles XVIII and XIX, and those areas that MMIS can bridge the gap. And it is to determine the extent that Medicaid and Medicare information systems have the potential for being consolidated or being built upon, to assure program effectiveness and administrative efficiency. This will be overlapping with a number of efforts that are already ongoing in terms of the integration projects and others, but we thought we would be remiss if the MMIS Task Force did not look at this very important and critical issue, as well.

A fourth goal is to improve the general systems design, specifically to review the adequacy of the GSD in light of design implementations by States in recent years and the improvements in technology out in the field, that perhaps have not been taken full advantage of by the Federal government to incorporate it into the GSD. It is also to seek to determine if there are additional information system requirements that would be beneficial to all of the Medicaid programs in the GSD.

The last and final goal is rather broad. It is to improve the areas for most effective execution of statutory requirements, particularly from the Federal perspective. This involves not only the Federal approval process, which needs to be seriously evaluated and upgraded, but it is also to develop the research and demonstration strategy for testing various innovations in MMIS, for identifying whether or not there are legislative changes that need to be made within the law in order to assure MMIS is as effective as it can be; to assess the various functions and resource requirements, including staffing, asociated with these various goals that we have talked about earlier; and, finally, to identify some areas for training programs to ensure the effective implementation of MMIS.

A work plan has been developed, consisting of four phases or four steps. Phase I is to identify what is presently wrong with MMIS, or, rather, what are the current stumbling blocks which impede it from being

as effective as it possibly can be. A lot of work has gone on over the last several years, and we don't want to reinvent the wheel, so some of this has involved an analysis of existing studies, as well as a number of interviews and questionnaires that have been sent out, and are being sent out, to evaluate what are the stumbling blocks.

A second phase is to take a crack at developing some preliminary recommendations aimed at addressing the five goal areas. The third phase, then, once we have these preliminary recommendations worked out, is to weigh the cost benefits of the various recommendations to make some sort of an objective assessment as to the effectiveness of the various recommendations, and sort through them in terms of time, resources, staffing requirements.

Phase 4, is then to make sure that there is a plan of implementation, which identifies the organizational units most likely to carry out the responsibility for implementation, and to develop a tracking mechanism by which the Steering Committee and the leadership of the Task Force can hold the organizational unit's feet to the fire, making sure that the recommendations are, indeed, implemented and simply don't sit on a shelf and collect dust.

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MR. STANSBERRY: In trying to get down to the task of doing the project NTAG, the commitment that has been made by Dick and Mr. Schaeffer, I think we need to look at really what MMIS is and what are some of the goals in addition to what Rick has outlined, and what some of the regulations and guidelines point us to.

Just to get in a perspective and, hopefully, not be redundant, MMIS is an abbreviation for Medicaid Management Information Systems. It was recommended and conceived as a computerized claims processing system to provide information for efficient, effective and economical administration of State Medicaid programs.

Some of the legislative or regulatory requirements emphasize that the systems developed should be providing prompt written notice to individuals furnished Medicaid services. The second item would be to be compatible with the claims processing and information retrievable systems used in the Medicare program.

The third item would be to provide both patient and medical provider profiles for utilization review and program management purposes, and, lastly, to be fully operational.

I think to review and attempt to set up some performance standards, you must get all of these in perspective. We have met on two occasions since the Albuquerque meeting; first, in February, to review the purpose and goals, try to get in perspective what this group would be formulating and how it would function within the Steering Committee and Task Force of Mr. Heim.

In the first meeting in St. Louis, we went over some of those, developed some work plans, and identified individual State participants to come up with some guidelines, proposals for performance standards. In the second group meeting, we went over some of those, and as those are developed, they will be relayed to you.

I will reiterate some of the items which we covered in the director's meeting. That is, that these State representatives are there for your input and communication. I would like to call their names and to give you a little of what they have touched on.

I would like to introduce two of the members who are also at this meeting: Bob Melvin from Georgia, and Bruce Kozlowski from Michigan.

In our first meeting, Bruce commented on the GAO report about Michigan, Washington, and Ohio, and that they requested specific information, data information being programmed into the system, but that neither program guides nor the general system design do not explain how to use each data element. But, yet, the Federal people criticized us for not making use of the data elements.

These are some of the topics that we have gotten into in regard to how to redefine the data elements and performance criteria, what the Federal people will be looking at, what the State people should be looking at in the data element area. We will be asking for additional input and discussion on those from each of you. I am making these names known so that if you feel strongly in any of these areas, you can contact these people.

Mary Aubrey, from Texas, discussed the thoughts on integration with various programs, AFDC, and also discussed the possibility of a data element dictionary, which I think all of us are aware we need to have some common descriptions of what each phrase we are talking about in MMIS means.

Al Miller, from Pennsylvania, commented on the manual interfaces, and the impact on recommendations of the State staff, to follow up a little bit the interfaces of the Federal staff, in order to communicate the concept of improved performance standards.

Warren Peterson, from Minnesota, commented that he felt like the medical information could be used as a professional management tool. Izanne Leonard-Haak, from Pennsylvania, brought up the concept of improved communications or best practices dictionary for innovative systems.

Bob Melvin, from Georgia, discussed and commented on the Regional Office and Central Office communicating with the States and being more supportive of what the States are doing, and being constructive in their criticism. Derek Wong, from Idaho, would like to see some guides or steps developed for MMIS planning and contracting. Derek presented a very good paper at our last meeting on being prepared, both on a Regional level and Federal level, for the States to begin looking at MMIS, what steps they should be taking to develop a system, where they could go for information.

William Corby, from New Jersey, thinks that our Federal partners could do more on developing the capability of the individual modules, going into eligibility, as well as the service system. As we discussed, there are about as many service systems as there are Title XIX programs. And I discussed the feasibility of being fully operational, and whether or not the individual State plans were looked at insofar as being completely turned on.

These are the current representatives from the State side. Again, I ask that you communicate with them, let your feelings be known, so that we do take advantage of this opportunity to input.

We have, as a group, answered questionnaires from the individual members. They will make available a questionnaire for the State directors.

In addition, I want to make you aware of new legislation. Senate Bill 731, by Senator Schweiker, was just introduced on March the 22nd. I think it encompasses many of the projects that this Task Force, as well as some of the integration projects, have attempted to do.

We appreciate the confidence that you have shown in us in establishing this Task Force, and we want your input.

Thank you.

MR. SILVA: A few points I would like to touch on, that Howard mentioned, from a little different perspective, and that is on the Federal side.

Before I get into that, however, I would like to make a comment on the evolution of the National Technical Advisory Group. It was formed in Albuquerque, as mentioned, in response to a couple of items, one of which was the GAO report on MMIS, and, secondly, Mr. Schaeffer's speech in Albuquerque, which was very heavily oriented to MMIS and the needs and opportunities that MMIS presented as a management tool for States.

The formation of the group in Albuquerque was the first and an important step in what was to ultimately become the purpose of the group. It is probably not accurate to describe the group, as its title infers, as a National Technical Advisory Group.

It is much more than an advisory group, in my view. It is true, in a number of areas, that the State representatives on the Advisory Group have, indeed, made a number of recommendations to HEW, both to the MMIS Task Force and Steering Committee, as well as to the Medicaid Bureau.

But I think the value of the Advisory Group has gone far beyond that. It has gone into the areas that I think we are all most concerned about, and has gone into those areas in great depth. It is a group that is rolling up its sleeves, and working. It is a group that is struggling with some very difficult issues, issues that admittedly should have been faced a long time ago, but have not been.

So, although its title is Advisory, the nature of the group, and not only the nature of the group, but the nature of the individuals in that group, has said that we ought to do a lot more than advise. In that context, each member of the group has assignments that they report on in subsequent meetings. And the next meeting that we are going to have in a couple of weeks, is going to be a very important one for all of us.

In that meeting, the various members will report on their concept, their ideas of what are performance measures in each of the modules or subsystems of MMIS. It is a difficult, but very important step.

After much deliberation and a little dissent among the participants at the last meeting, I think we finally got ourselves straightened around, and I think a great deal of credit goes to the leadership of the group, Mr. Stansberry and his colleagues, on getting us away from some things that, albeit extremely important, were not as important as the more critical issues we all face right now, and that is in the area of performance.

I don't want to underplay the other aspects that this group also has been involved in, and the recommendations that it has made. One of the items that comes through quite strongly is the need for having better, more complete, more frequent exchange of information about what various States are doing, how they are doing it, who the people are in the States

to contact to get advice.

We are in the process, within the Institute for Medicaid Management, of increasing the amount of information which you will find in the Medicaid Management Exchange.

In the future, you will see more charts, tables, et cetera, specifically devoted to various aspects of MMIS status or MMIS information from each State. I would like to make a pitch to have all of you in this room make contributions to that particular publication. Individuals that I have spoken with in the past, who have read it, have commented on its utility, because it is quick reading, it is very succinct, and it gets across interesting and informative bits of information in a quick fashion.

We are hoping to accelerate the publication, so that we get more of the MMX out to you on a more frequent basis.

Other areas that they have told us that need some help, are more sessions such as that held in Albuquerque. For those of you who attended the Albuquerque session, I think that I can fairly restate the thoughts you expressed to me, which was that was one of the most useful sessions that HEW has sponsored in quite some time. We intend to seek, through the NTAG, their advice and recommendations for subsequent sessions.

A number of areas, that have been presented to us by the NTAG, sometimes are difficult for Feds to swallow, because we think we are doing such a good job that we obviously overlook some items. There are a number of areas they have given us advice on, on what we should do, and, more importantly, how to do it. Some of those areas fall into such categories as contracting. As mentioned, Mr. Wong from the State of Idaho had commented on the need for States which are small, and States which are coming on-board in MMIS, to have some assistance on the first step on how to develop a feasibility study, and carry that through to completion, to know whether, indeed, they ought to have the MMIS effort developed in-house or contracted out.

There are a whole bunch of other areas that NTAG has gotten into. There will be a lot more areas that they will be getting into as we roll along. It is important to note that the NTAG is not a self-destructing unit, although we almost reached that point at the last meeting.

It will go beyond the tenure of the MMIS Task Force and Steering Group. It is a group that we see existing for some time to come, a group which we see as being a viable entity, that will address continuing problems of MMIS, and to continue to advise HEW on the policy matters that will impact on MMIS.

This becomes critical when we consider the functional reorganization of the Health Care Financing Administration and the extent to which the Medicare and Medicaid operational parts of the program will be coming together.

So, I see that the future of NTAG -- after we get some of the initial

business behind us -- is going to focus on some of those very critical integration projects, which I know a lot of you are involved in now.

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MR. NAKAMOTO: Some of you may wonder why there is such a big emphasis in the area of information systems. We took a little survey of some of the more automated States, and it indicates to us that approximately 30 to 50 percent of their administrative dollars goes towards the cost of automation.

Now, if you apply that nationwide and say that all of Medicaid is highly automated, or close to being highly automated, that represents an administrative expense of about $500 million a year, and that could be a significant impact in the way that you do your business, and the way you handle your organization, and the way you manage whatever you need to manage.

I think the biggest impact that we see right now in HCFA, is that Len Schaeffer and Dick Heim have given us the kind of an organizational climate for improvement. Of course, they have given us an organizational change, too. But part of that organizational climate for improvement is the use of technology, and I think it becomes incumbent upon us, the so-called working members of the Task Force, to bring in some kind of feasible technological improvements in the process of health care information systems, and a lot of the Task Force work will be focusing on that.

We are also focusing on the relationship of organization as it relates to the use of technology, and as we do our work, and even though the Task Force work may be over, I think you may be looking at new patterns of your own organization, a new kind of budgeting emphasis, and perhaps new skills that you need to have to improve the administration of Medicaid, as we know it now, in State government.

One of the provisions in Senate Bill 731 mentioned earlier, is that all States must have something like an automated information system by January 1, 1983, and if they don't, there are some administrative penalties associated with that. I have no idea as to the status of that legislation, whether it is going to be passed, and all that. But there is a lot of interest, not only within the administration, but on the Hill, about moving and improving the information systems related to Medicaid.

In the area of performance standards, we realize that performance standards from MMIS cannot be established in a vacuum, and that they have to be meaningful in terms of programmatic goals and also in terms of the administrative structures of various State agencies. We will come up with some initial list of performance standards and will come up with recommended lists of other performance standard areas that need to be looked at further.

The thing that we are very concerned about is that whatever we come up with in the area of performance standards is realistic, practical, quantifiable, definable, implementable, and so forth. And we are taking a

very hard approach to make sure that what we come up with is, in fact, workable. In that respect, the National Technical Advisory Group is looking at the six subsystems of the MMIS, and coming up with some performance statements about that.

We also have another group looking at the performance standards related to the eligibility component of Medicaid, because it seems like there are some 25 States and local jurisdictions that are involved in a common eligibility data base project, whereby Medicaid gets its eligibility data, but it is also co-mingled with Title XX, Title XVI, Title IV(A), IV(D), in some cases, and other kinds of State and local services.

One of the things that we have a strong effort going is to make sure that we will come up with some recommendation, which will establish a definite link between the outputs of the MMIS and the inputs into the Fraud and Abuse Units where States have them, and we will have some definite things to say about that.

Another area which requires a lot of thought -- and we get a variety of criticism, and we really can't pinpoint it yet -- is that we need to improve our so-called reporting system, especially in the area of management reporting and the surveillance and utilization reporting, and we have a group looking at that.

In the area of coordination, although the integration projects have been mentioned, our coordination efforts have gone a little bit further than that, and we are looking at coordination with the SSISDX system, the IV(A) eligibility system, and also in terms of the actual data element requirements on PSRO.

We are trying to find some way that Medicare and Medicaid Information Systems can find a way to feed the PSRO data system in terms of the kind of data that we have without going through an individual collection method of the PSRO. That is a very controversial area, and we will be stepping lightly, but we will be coming out with some recommendations in that area.

In terms of improving the general system design, we are looking at it in two ways. One is a technological update, and, again, we talk in terms of minimums. But a lot of people have talked about things like distributed data processing, talked about things like communication linkages, remote data processing, data base considerations, more ideas on generalized software packages, things like that.

We need to update some areas such as long term care and some version of EPSDT. And, also, some of the States have come in with advance planning documents for a financial management system to support their operations, because although MMIS handles bills and pays bills, it seems not to do much in the way of a budgeting process.

On the Federal approval process, we will be getting out some regulations on incremental approval and incremental disapprovals.

We are also concerned with the whole Federal approval process in several areas: how long does 90-10 money exist, when is the effective date to switch to 75-25, what should be included in 75-25, and what happens when you get down to 50-50?

Again, I would like to emphasize that the primary purpose of this whole exercise is to see what we can do in having the right kind of information system, so you can effectively manage your program, and part of that management process is to establish a management control over your program so you can say that, yes, I understand what is going on in my State administration of Medicaid. I can account for where my dollars go, I can tell where my fraud and abuse activities occur, and I can account, not only to the beneficiaries on one end, but the taxpayers on the other end, as to precisely what is occurring in my program.

MEDICARE-MEDICAID INTEGRATION

Lawrence Levinson
Project Officer
Medicare-Medicaid Integration, HCFA

MR. LEVINSON: When HCFA was created back in 1977, one of the goals of the Secretary was to integrate Medicare and Medicaid.

HCFA has done a number of things since then to reach that goal. The latest, of course, has been the reorganization that was announced last week. We have also done a number of things to try and integrate the two programs, to bring them closer together, and I would like to talk to you about those efforts today.

We call this effort "the 20 projects" because when it started out there were 20 projects; now, there are fewer.

We started out on a project team basis, with representatives from the different bureaus in HCFA, for a number of reasons. First, because there was not a cadre of people with expertise great enough to handle all of these areas. And, secondly, because we felt it was time that we got the bureaus talking to each other and participating in the decision-making process together, rather than the separate paths that they had been taking up until now.

We also made sure to have special links set up with the States, particularly with the American Public Welfare Association. For each of the teams that we have, the APWA and its Medicaid Directors' Council has created a "shadow team" that has worked with our teams to provide State input, to let us know when we were going wrong, and to let us know when we were doing right. This has not always worked as well as we would like, with some teams not adequately participating, although most did work fairly well.

What I am going to talk about does not involve HCFA policy. For the most part, these are not decisions that have been made but rather proposals of the teams.

We welcome any comments or suggestions that you may have as far as ways that we should proceed, additional areas that we should be looking at, or corrective action that we should be taking.

We have divided the projects into a number of different categories. The first one relates to those that involve the claims process, and we have about six or seven in this area.

The first one relates to common provider identification numbers. The Medicare-Medicaid programs deal, in many instances, with the same providers, yet, generally, have separate systems for enumerating providers in the States, thus making it somewhat difficult for us to do appropriate utilization checks on a postpayment basis. It means that providers have to be aware of several different numbers that they are using in the billing process. It also means that when you are dealing with a subject like crossover claims, it becomes more difficult to process the claims.

We thought it would be a good idea to have a common provider number. We also thought it would be relatively simple to do that. That is another instance of our naivete. You will see a few others as we go along.

On the institutional provider side, the team was going to recommend to the Administrator that the six-digit number that Medicare uses, the certification number, should be expanded to include all Medicaid and Medicare providers. We also were going to recommend that Social Security numbers or EINs be used for noninstitutional providers, physicians, and dentists, etc.

We have more and more of a problem dealing with the Social Security numbers. There is a lot of resistance to Social Security numbers on the parts of physicians. They don't like using them. Medicare, particularly, has had a lot of problems using them.

And, in addition, if you are going to use single identifier more, you might want a State code if you were the Federal government, and you would probably want a type of practice code, a type of specialty code if you were a State agency or Medicare carrier.

So, we pulled back the paper that we initially sent around for draft, which recommended the six-digit number and the Social Security number, and we are now looking at the feasibility of implementing a new numbering system. I don't know how feasible it is, and at this point, it is really very early to say what we are going to do with this.

The second project relates to a common medical procedural terminology and coding system. This is a project where we have made good progress, and a paper has gone to the Administrator with a recommendation that CPT-4 be used for all physicians' medical procedures.

Now, you are aware, of course, of the HCFA announcement about ICD-9CM in hospitals, and you may be asking yourselves, "this seems somewhat inconsistent using two coding systems." That is right. There is a workshop that will be held later this week, where the author of the paper on CPT-4 and some people, who are experts in ICD-9CM, will sit down and explain the systems to you.

However, we are recommending CPT-4 and are hoping that he will accept it. The CPT-4 is a five-digit number. It is used now. CPT-4 and another five-digit number are fairly common in most States. However, most Medicare carriers are using CRVS or a derivation thereof, which means that they will have to do a good deal of conversion.

The next project in the claims' processing series relates to a common claim form for physicians. A draft paper has been written, has been circulated, and is now being rewritten in preparation for submission to the Administrator.

The recommendation is going to be that the AMA claim form, the HIAA claim form, with significant changes to accomodate the Medicaid State agency's needs, be adopted for Medicare and Medicaid. That is what we are going to recommend to the Administrator. In addition, we will be preparing an optical scanning version. So, for those States that use optical scanning, there will be a version for them.

There will probably be a separate EPSDT form, although I am not certain about that yet. The form, as it was originally designed, for those of you who are familiar with it, has always met the Medicare Bureau's needs. They used the SSA-1490, which is a relatively simple form compared to many of the Medicaid forms that are in use.

The problem that we have had, and the issue that has taken us so long, is trying to accommodate the Medicaid State agencies' data needs on the single form. We have worked it down to the point where any data element used by more than 25 percent of the States is on the form, and there is room on the form, in the remarks section, for States to put down individual data elements they require.

One aspect of our recommendation, that you may find interesting, is that we are going to recommend that the United States Government print the form for all the States and provide it free to the States, and at cost to third-party carriers. Again, that is what we are recommending, the idea being that we can print it at GPO, even with overprints for individual State identifiers and other things that you are going to need, cheaper than you can print it in your own State, since we will be dealing with such a large volume. An elderly beneficiary in the Medicare program, who was dealing with a physician who did not take assignment, could probably not fill out this form appropriately. So, we will be designing a short form for the non-assigned claims in Medicare to accommodate that population.

Related to this is the next project, which is a uniform bill for hospitals and UHDDS. The uniform bill for hospitals is UB-16. It is being tested right now in a number of States. Ohio has had it in place since January 1 for Medicaid, and Medicare and other third parties are supposed to be effective April 1st. Florida and Connecticut have been approved for testing. Arizona is close for approval. And there are a couple of other States, including Nevada and South Carolina, that we are also considering for testing this form.

We are waiting until the end of the year to get some results, to see whether or not there are savings. The American Hospital Association believes that there are savings to be enjoyed by using a common form.

New York State is using UBF-1, which is their own uniform form, and it is something that is even more complicated than the UB-16.

UHDDS, the Uniform Hospital Discharge Data Set, is a part of this project, and it has been a part that has been giving us some problems. We are expecting an NPRM to be released.

One concern that we have had is that UHDDS, which is a collection of data elements on the discharge side, and the uniform bill, which is a collection of data elements related to billing, are almost identical. Except for perhaps less than a half a dozen data elements, they are identical data sets. They include the same information.

It doesn't seem to make a lot of sense to require the same informa-

tion two times from the same provider, and we are taking a look at the whole concept of billing on the hospital side, to see if we can merge it with UHDDS to make a little more sense.

One project that I know is dear to the hearts of many State administrators is the one relating to level of care in skilled nursing facilities. The problem has been, very generally, that Medicaid has felt that Medicare has been too conservative in its interpretations, thus denying too many claims and, causing the Medicaid State agencies to incur costs they don't think are right.

After looking at the situation, we found that is probably true, and we have set up a group that looked at the guidelines being used. There is no real problem with the regulations, as we could tell. The problem is with the guidelines, the way they are being interpreted on the local levels.

We have done a number of things. We have prepared a new set of guidelines, and we have prepared them in very close working relationship with people from the States, from Michigan, from New York, and from Oklahoma, particularly.

We are a little nervous because everybody is agreeing that it is the right way to go. Both Medicare and Medicaid think it is terrific. It has gone through the first initial review stage, and everybody said it is fine.

We will be distributing it to the Bureaus, we hope next week. I would guess that the Bureaus will be sending it out for comments.

We think this will solve the problem. After we do the guidelines -- though we recognize that issuing new guidelines is not enough -- we will then be providing a training program for the State agencies and the Medicare contractors in every State to make sure that, at least when they leave the room, they say they believe the same things.

We will also be following that up with a monitoring program to make sure that the decisions that are made are reasonable. There will also be an appeals process with the HCFA Regional Office where, if a State or Medicare contractor or PSRO, or whatever, feels that a decision is incorrect, they can appeal it to the Regional HSQ director.

We have completed a project. It relates to common coverage of lab services. The problem was a relatively simple one. There is a regulation that says that Medicare and Medicaid should only reimburse laboratories for those specific services for which they are certified.

Medicaid was not following that as well as we would have liked to have seen. A number of States were ignoring it. We have reinforced the instructions. We have provided some additional information to the States to make sure they know what services are certified.

It is being built into the Bill Processing Systems Test, and is going

to be built into the State assessment program.

The last projects in this category relate to crossover claims. There are really two of them, one of which we call expanded information exchange between the two programs, and the other one, more simply, is a processing of crossover claims.

First, we are trying to improve the data exchange between the two programs by improving the BENDEX, by improving the HI master file in Baltimore, so that you will be getting better and more current information.

We may well be making it a requirement that you use the BENDEX for the information that we give you. And we are hopeful that that kind of information exchange, with a standardized data set will be useful.

Now, we know that some States have already worked out agreements with Medicare, with the contractors, to provide an exchange of information at varying rates, and we are not going to be interfering with that. But we think that this process will simplify things for those States that haven't; it may simplify things even for those States that have.

The second piece of this is devising a system where we can actually process crossover claims more efficiently. Processing of these claims varies. Crossover claims, of course, are those for people with joint Medicare and Medicaid coverage; about 15 percent of our population. In many situations, a provider performs a service and will bill the Medicare program. Medicare processes the claim, pays the check to the physician, who then must bill the Medicaid program for the co-insurance and deductible.

Some States have worked out arrangements with the carriers to process these at the same time, and the providers only have to bill once. Other States have worked out agreements where the carrier provides information directly to the State, and the State processes the claim again with a second bill from the provider.

We are attempting to determine whether a single process is the best way to go. We will be testing a process in New York, using the Division of Direct Reimbursement in Medicare, and the Health and Hospitals Corporation in New York City, and the New York State Department of Social Services.

One of the reasons we chose New York, is the fact that DDR is the Medicare contractor, and DDR, of course, being a Federal arm, would give us a little more control on the first experiment.

We are looking for other sites on crossover claims. When I say that, I don't mean that we are going to be starting a couple of new experiments next week, but we are interested in a couple of other sites, and we have had some expression of interest from a number of States. I would think that probably later in the year, or perhaps at the beginning of the next fiscal year, we will be implementing a couple of other tests.

The next project relates to common standards for fiscal agents. Medicare has got a set of standards. They are issuing new standards. Medicaid, for the most part, does not have standards to measure performance of fiscal agents or State agencies.

We did want the standards to be relatively similar. One of the reasons there has not been much progress on this is we have been waiting for Medicare to finish its set of standards, so that Medicaid could then tie into them as well as they could.

Medicare has finished. Medicaid is working on standards. There is going to be a presentation later on this week on standards, and this is going to be a push on this; there is going to be much more emphasis on quantitative and qualitative standards.

We are also trying to get our act together a little better on the issue of workload reporting and administrative cost reporting. We don't have good figures now on what is happening in the States or with the fiscal agents as far as numbers of claims being processed, cost of claims, unit cost. We would like to be able to get a better handle on what is going on, and we would like to be able to get the information in a form that would at least be compatible with the kind of information that Medicare collects.

We are working on this now. One of the biggest hang-ups we have had is the definition of a claim. The definition of a claim is very different between Medicare and Medicaid, both of which cause distortions in figuring, but both Bureaus think that theirs is the best way. We have been somewhat hesitant to force the decision as to which definition is going to be used. But we are reaching a point now where that is going to happen.

We had a project on joint review of fiscal agents. When we started, there were about 19 States which had common fiscal agents, and it seemed more important than it is now with only 10 States with common fiscal agents. But this is something that we are interested in. We would like to reduce the burden on the fiscal agents. We would also like to make sure that the kind of review process that Medicare and Medicaid use are compatible.

That is really the thrust of where we are right now. We are going to be taking a look at the review processes and try to design a common process, not to be used right now because, at this point, Medicare's needs are different than Medicaid's needs in the review process.

Medicaid is, in many instances, still in the process of accumulating information on the operation of the State agency. Medicare has had about 12 censecutive years experience in performing these kinds of reviews. Medicaid has not had that kind of extensive experience.

So, probably we would let the Medicaid State agencies' reviews continue the way they are for the first cycle, and at that point, try to implement a more similar review.

One thing that you may have noticed, is that there are a number of instances we have talked about where Medicare and Medicaid don't use the same words to define the same thing.

"Provider" and "supplier" is an example. "Claims" are defined differently as are "beneficiaries" and "recipients."

So, one of the things we have been trying to do is to make our terminology more similar. We have identified a list of 24 definitions, which have been distributed. We are not really happy with it, because it doesn't seem to really get to the meat of the issue. So, we are looking at that, trying to determine the best way of dealing with it. We are also looking to get common language in contracts where appropriate, and perhaps common language in systems and specifications appropriate.

A couple of projects relating to reimbursement. The first one is common audit, the common audit hospitals particularly. Thirty-seven States, at last count, enjoy the benefits of common audit between Medicaid and Medicare. We would like to have the rest of the States involved in the common audit process.

There is some talk about mandating common audit; whether or not that will happen, I don't know. What we are trying to do is to make it so desirable for the States, that they will just want to do it.

We are going to recommend a number of things, not the least of which is that the information be provided to the States free, rather than at cost. We are also going to recommend that States not be reimbursed for duplicate audits. If Medicare has already done an audit at a hospital, we don't see any reason to reimburse the State for performing the same audit.

We do recognize, however, that the Medicaid audits are not identical to the Medicare audits. There are areas within the audit that are different, and those would continue to be reimbursed at the regular FFP rate.

So, what I am saying is, first of all, we will give you the information for nothing. Second of all, we won't reimburse you for duplicate audits. We will reimburse you for the incremental audits. This is what we are recommending. We still have to see whether or not the Administrator will buy it. There will be a net cost to the government of about $3 million, but we believe that will be made up by the improved audit and the elimination of duplicate audits.

Some of you may have heard of something called the Uniform Cost Reporting and Accounting System, otherwise known as SHUR. It is a system to provide a uniform system that institutional providers have to utilize in reporting costs.

It is something that we think is very important. It is something that is very controversial. Many hospitals in this country are very much against this. An NPRM was issued announcing what we are going to do, and

we are now getting comments back.

We are dealing with a uniform chart of accounts for reporting, not for internal accounting processes for the hospitals. We are waiting to see what happens after the comment period, and you will be kept advised as to what is going on. At this point, nothing is happening. We are just collecting the comments and analyzing them.

One project that has caused some concern is the one relating to common overpayment recovery monitoring system.

Medicare has got a system where any time a provider owes it money, they can tell you how much it is, the identity of the provider, and the amount of money owed, etc.

Medicaid doesn't have that kind of a system, and we thought it would be a terrific idea if Medicaid had a similar system, so that we could then see whether providers were owing both programs money, how much money was being owed, and how the money was being collected.

There were a couple of factors that weren't fully considered when the project was begun, one of which was if we require you (State agencies) to report the overpayment or an erroneous payment; then we would immediately withhold the money on the next grant payment.

There is no real incentive for you to report overpayments. We figured that out. It took several months, but we figured that part out. We then learned that for most States, the process is an automatic one as far as recovering the overpayment, so that it isn't a process as in Medicare, which often drags out for a number of months or years. So, we are taking a look at this again to see whether or not we still want to do it.

An alternative presented was, (since many States tell us they collect the money within the first quarter that the overpayment is identified) to give a quarter's grace period, and only count overpayments pending over two quarters, but I am not sure exactly what is going to happen to that.

Related to this is a project on joint offset to make sure that overpayments in either program could be offset by payments in the other program if this was required. This requires legislation. We have asked for that piece to be put in the Fiscal '80 package.

What that means, of course, is if a provider owes both programs money, drops out of one program and stays in the other, we can collect from payments due in the program they are still participating in.

There are two other projects, and then I will just tell you a little bit about what we are going to be doing in the future. Medicare and Medicaid, again, in dealing with SNFs, have not started SNF participation in the programs at the same time. When SNF applies for certification and then goes through the survey process, we didn't start them at the same time. HCFA has issued an NPRM indicating our intent to have Medicare and

Medicaid both start participation of a SNF, either at the time that it has corrected any deficiencies, or at the time it has submitted an acceptable plan of correction. The NPRM was issued a couple of months ago. The comment period is almost over. It seems to be a relatively noncontroversial issue, and you should be seeing a regulation on it relatively soon.

Medicare has been spending a good part of the last year trying to improve its Explanation of Benefits form: to improve the format and also to improve the language, to make it more understandable for its beneficiaries.

We thought it would be a good idea if Medicaid did a similar thing, improved its EOBs in those instances where it provides EOBs, and also provided a form similar in format to the Medicare form, so that at least a recipient would recognize the form as an EOB.

This project has not progressed very far. Medicare is still working on its forms, and Medicaid is now working on improving the language so that we can provide stock language for everyone to use on a very simplified basis for recipients, so that it will make it easier for them to understand.

This project loses some of its priority when you recognize that you are dealing with a sample of EOBs in most States, probably almost all States. But we are trying to see to it that the form is similar.

We are now eagerly looking forward to the next set of integration projects. Three have been proposed for initial investigation. Rather than setting them up as Form I projects, we want to do a little more of a feasibility study this time than was done on the last set.

One of the three areas that we want to be taking a look at is common beneficiary identification number. Medicare uses the Health Insurance Claim number. Medicaid uses different numbers. We know that there are problems with getting Social Security numbers, for instance, and problems with confidentiality.

The inclination of the people setting this up is that we would all go to Social Security numbers, but that is only an inclination. We were burned rather badly on the provider side, and we may not jump into that quite so quickly on the recipient side.

A second area we want to take a look at relates to automated systems in HCFA; to see whether there ought to be more commmonality. The law says the systems have to be compatible.

We want to see whether, for instance, MMIS should be exported to the Medicare side. Medicare had a model system for a long time and has only recently stopped pushing the model in favor of having a number of different systems.

We just want to take a look and see whether that concept should apply

to both programs, or whether we should just leave things the way they are, or whether we should try to get more commonality in the system. The third area we want to examine is the quality assurance activity to see whether there should be more commonality there.

Fortunately, the reorganization provides a unified quality assurance group within HCFA, so we can let them do that. And it provides a unified systems group within HCFA, so we can let that group examine the systems issues.

To summarize, we have completed one project successfully. We have gotten developmental work completed on about a half a dozen. There are 11 projects still in various phases.

The first group that I talked about, the claims' processing ones, are the ones that seem to be moving along the best, and those are the ones that you should be hearing the most on.

We think that one of the best results of these projects has been that for the first time in 12 years, the Medicare and Medicaid Bureaus particularly, and the other bureaus within HCFA, HSQ, for instance, are finally beginning to talk to each other on an operational basis, and to begin to understand the problems that each bureau faces. We think that that is progress, certainly when compared to the kinds of understandings that people had when we started. At any rate, this process will probably be amalgamated into the reorganization, and will probably be placed within the functional organizations that have responsibility for the specific activities.

We will probably continue the close relationship we have had with the APWA people, because that has been very productive for us. We welcome any comments that you have, or any suggestions, or any questions. If you have any later, you can call me back in Washington. If you have any now, I would be happy to try to answer them or respond to them.

EPSDT AND CHILD HEALTH

Panel Participants:

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DR. TIERNEY: There has been a great deal of activity going on in the area of child health. The Secretary has become extremely interested in the program. There is a great deal of pressure on HCFA and, suddenly, we have become one of the big programs within the Health Care Financing Administration.

Let me just speak a little bit about what we're thinking about in child health, in our general child health strategy, how CHAP and the penalty regs, and everything else, fit into this scheme.

I'm sure all of you know the history of the program. In 1967, the EPSDT legislation was enacted in part as a result of the fact that, during the Vietnamese War, a great many inductees were not able to pass physicals. They found a great deal of defects -- physical defects -- that they thought could have been cleared up through early physician and provider intervention.

As a result of that, the EPSDT legislation was enacted, and it was a very short piece of legislation; it wasn't altogether clear what this was supposed to do. They talked about early screening and diagnosis and treatment, but nobody really knew how it fit into the scheme of the rest of the health care system.

When the legislation was not implemented by the Department, the penalty legislation was then, in 1972, enacted by the Congress. A one percent fine against AFDC funds was to be taken if the State was out of compliance.

So, essentially, what we have is a program in which nobody really knows what the thrust should be, at least from the legislation -- and even from the regulations, which were then developed.

What Len Schaeffer and what Dick Heim, I know, think of the way this program should be is that it should focus not on merely screening children and not on getting them into treatment, but, ultimately, trying to make EPSDT, CHAP, or Child Health, preventive health services for Medicaid-eligible children.

There shouldn't be a Medicaid ambulatory care system and an EPSDT ambulatory care system to the point where, for example, the American Academy of Pediatrics has a classical picture in which there's a screening van sitting in the front of a pediatricians's office grabbing the kids as they come out of the office. Physicians should be able to use either the Medicaid or the EPSDT claims form, et cetera.

So what we've been doing is trying to walk through what the problems are with the program, what the strengths and weaknesses are of the program. There are no terribly easy answers. Twenty-nine States, for example, currently utilize primary care practitioners. Another 24 States rely primarily on screening clinics with referral to private practitioners, and other types of hospitals and clinics.

There is really not any great experience which says which one is

better, which one is preferable. States vary greatly, of course, in the number of physicians they have, in the strengths and the weaknesses of their health departments, and so on. And this is the kind of thing that has to be taken into consideration when you are building up an EPSDT system.

But, specifically, we have identified three areas in which we see that there are some fundamental problems with that, and that would be program management, program incentives and the use of program resources.

Under program management, EPSDT requires States to carry out a wide range of activities to support program goals, such as case management, case finding, and it also requires, ultimately, an extensive data system to support something like this to make sure that we know what children are under care and where. Obviously, we don't have that kind of system.

One measure of program success -- and the Secretary keeps emphasizing this -- is the screening rates. And they talk about why the screening rates aren't up. What we've been saying is that perhaps we're looking at the wrong thing as a measure in and of itself. There is nothing wrong with screening children, and there is nothing wrong with trying to get them into treatment; it's just that it is not the "be all" and the "end all" of the program.

In addition, there are really no program incentives, either positive or negative. We are still sitting in limbo with the penalty regulation, but beyond that, it's expensive for the States, as you well know, to implement such a program. There is no fiscal relief. At least there is a great deal of front-end expense in implementing the program. And there was really basically no positive reason for States to get into the game of trying to get children under care.

Another problem is the use of program resources, such as providers. We really haven't adequately used either the private sector or the public sector, such as the Comprehensive Health Centers, and the Title V Clinics, et cetera, to the best of our knowledge.

There are a lot of kids getting care out there, and I think we're being kind of slammed over the head because we're probably doing a better job than we think we are, but we simply aren't "counting" these children as being under care because they aren't getting into these screening clinics. So that's another problem.

So what we've done is to try to see how, in some kind of a coherent way, we can attack this problem. We've got basically three goals: we want to improve program management; we want to provide incentives to States to get into this game; and we want to improve the use of existing health care sources.

Under "improving program management," we want to eventually develop a data management system that would be capable of monitoring and evaluating the program. We want to know where children are within the health care

system, so that we will be able to outreach those children that are not getting care. On the other hand, those children that, for example, are in a Title V Clinic, we don't have to outreach, rescreen, retreat, and then find out that they are already under care. This is a waste of time and money.

Second of all, we want to develop -- and we are going to finally get out -- a definition of equivalent care. This is something I'm asked all of the time. The equivalent care package is sitting in the Office of General Counsel's in-box, third down. He's got two other pieces of work before he signs off on it. It's been a long time in coming.

Basically, what we're saying is that the State, in cooperation with the Feds, determine what they feel is adequate care that would be equivalent to that offered by the EPSDT program. It's not going to matter if a State or the provider provides it all in one spot at one time.

For example, dental and medical, if they are going to a comprehensive health center or a private physician and there doesn't happen to be a dentist on the premises, you can still count the fact that this child is under care at this clinic, and then worry later on about getting him into dental care. What we don't want is to be so rigid that it can't be counted simply because there is not a dentist right on the premises. If the provider will refer that child, or the State will refer that child, there is no reason why that can't be considered equivalent care.

Finally, what we are also asking for, to improve program management, is to provide some technical assistance which will enhance and support State capacity building efforts. Last year, 24 States asked for technical assistance. We were only able to provide 10 States with that. We are now asking for additional moneys, both in amount that would go to individual States and to expand it to the number of States so that we can work together to improve this program.

Our second goal would be to provide incentives to States. We have revised the penalty regulation and it's on its way to the Under Secretary.

Basically, what we are planning for example, process requirements which will cover how and when a State must inform beneficiaries. But not performance requirements, for how many children who request screening, are actually screened and treated. We would like to ultimately get out of the business of telling you, step by step, how to do it and try to measure what you're doing. You can then use your resources the best way you know how because, certainly, we don't have all of the answers from Central Office.

Second of all, the CHAP legislation. What we want to do is target our efforts in getting children into continuing care. We have developed a performance standard in the CHAP legislation which is a graduated rewarded penalty system based upon the performance standard.

During the first 18 months of the program, all States will receive a

uniform 4 percent increase in the match for ambulatory services for children and we'll help the States in their start-up costs.

Beginning in the second year, the performance standard will go into effect. How will that be mathematically defined? We don't want to define it in the legislation, but we do have a mathematical formula. If you define it in legislation, that means if it's wrong, or if there is a problem with it, you've got to go back to Congress and get it changed. It's a complicated formula. Basically, it is weighted slightly towards continuing care. The performance standard is not just keyed at those children who request screening or request services, but it's based upon all Medicaid-eligible children. So the more children that you get into care, the higher your match will be.

We are also going to try to simplify some of the administration problems by eliminating differences for assessed and unassessed children as far as coverage goes. We'd like to cover routine dental, vision and hearing, prescription drugs, immunizations routinely for all Medicaid-eligible children rather than having to track each individual kid.

And I also think that it gets people out of the bind. For example, a kid coming in with an abscessed tooth -- gee, you haven't had a screen; I'm sorry. You wait six weeks, and hopefully your tooth doesn't fall out by that time and maybe we can get you in to the doctor, and then you can get to the dentist, et cetera.

We'd also like to expand consumer awareness of the program. We're going to have a contract to go out for out-reach and with local community groups that can inform the population. I know the long-range program experience is that people who are indigenous to the community, who know the people in the community best are the best people to speak to the program and speak to the people in the area in which they live.

Finally, what we want to do is to make maximum use of all existing health care providers. We are now in the final stages of reporting back to the Secretary on how we are going to coordinate programs, at least on the Federal level, and also on the State level on the famous Wolfe Report.

HCFA has been asked to coordinate the entire answer to the Secretary. We are meeting with all of the rest of the programs -- Public Health Service, Office of Human Development, and the Social Security Administration to see how they can help us implement this program.

In addition, Dr. Richmond and Leonard Schaeffer have been sitting down together and getting agreements on how and what we can do for each other. We are trying to get the Public Health Service, for example, to help us out, and help the States out in providing information and data on what care these children are getting, when they are getting it, so that you can use that to track these kids on a State level, and so that you don't have to again fall into this bind of having a kid, under care, in a Title V Clinic, and then ending up having to rescreen him.

Finally, we want to encourage all existing providers -- private

providers, also, to become continuing care providers. The CHAP legislation has pieces in it that speak to continuing care; we are asking physicians, for example, to sign agreements to provide certain types of services. They will be at risk to provide these certain types of services.

They will take on some of the aspects of case management that the State had to do previously, and we will try to monitor that also. Finally, we want to provide incentives for providers through CHAP to become continuing care providers.

Another interesting thing -- and I know that it's a problem when I've talked to people in the States -- is that providers have a choice of either reporting on the regular Medicaid claims form or an EPSDT claims form. Oftentimes, the EPSDT claims form is more complicated. Also, the provider is frequently paid less for providing EPSDT screening than for providing a physician office visit along with charging for additional ancillary services.

We are proposing, in CHAP, a common claims form for ambulatory care for all children under 21. We are going to be working closely with the States. We hope to get some input from you; we hope to get input from the Public Health Service, from HMOs, and from many other people in order to help you so that you don't get caught in this bind.

MS. LYMAN: I was asked to talk about what the California CHDP, or Child Health and Disability Prevention program is doing, where it has come and where it has been. I've been in California for five months, and my four years before that were spent with the New York State Medicaid program, where I was in on the founding of the Child Health Assurance Program, or CHAP program.

It was a responsibility that I carried through until I left, so that, at times, some of my thoughts and ideas about this program are a little schizophrenic as I try to meld my experiences in two States together.

Going from New York, where the CHAP program had a certain degree of success and a moderate degree of visibility to California, where CHDP is a common household word among all kinds of people, is very exciting. And I think that's probably one of the greatest successes of the California program.

The CHDP legislation was written in 1975, and it did what I think many people have talked about -- it attempted to correct what many people saw as one of the liabilities of the Federal legislation. CHDP goes beyond the Medi-Cal eligible population, and it is intended to cover all children from zero to six in the State. Specifically, it requires that all children entering school present a certificate indicating that they have had the equivalent of a CHDP examination. Unfortunately, the only funds that were made available for the non-Medi-Cal-eligible children were for the school enterers and that funding covers only families up to 200 percent of the AFDC level. Every year, there is a little bit of hope that maybe this year we'll break through and cover some more children, but in the Proposition 13 era, it doesn't look like this is the year.

The CHDP legislation specifically mandates that there be a Child Health Board. This Child Health Board includes appointees of both the governor and the leaders of the legislature. The Child Health Board has met monthly for a number of years. It has been in full operation since 1977. And I think that is probably one of the great strengths of the program. This has been a highly visible, highly active board. Many of their members are influential in a number of circles, including the State chapter of the American Academy of Pediatrics.

Attendees at the meetings, aside from the members of the board, often include full-time practicing pediatricians who are also quite active in the State chapter of the Academy. It has been a group that has been both very interested in the program and has used considerable amount of its own time to promote it.

Some of this time includes visiting communities and talking with individual physicians, asking them to participate in the program. It's marvelous having this level of involvement and this level of interest to promote participation in the program.

We also require county advisory boards. Each county has a board that is made up of representatives of the medical community , parents of eligible children, and school health officials. That board is required to meet only twice a year, and while some of them have been more active than others, again it has been a form of promoting visibility at the county level.

This high degree of visibility has generated a tremendous amount of support for the program. It is also very interesting for an outsider to see how tremendously involved the Child Health Board has been at every level. For instance, when the State Department of Health was reorganized last year, the Child Health Board had very strong feelings about exactly where the CHDP program should be located, organizationally, and what level of functional responsibility it should have within the organization. So they keep close tabs on us at all times.

Basically, the CHDP program in California operates through the single State agency, which is the State Department of Health Services, but it requires close cooperation with two other departments; the Department of Social Services and the Department of Education. And this all translates down to the county level where the county departments of health have the responsibility to administer the program; the local school districts have the responsibility to collect the certificate of the examination from the school enterers; and the departments of social services have the responsibility for contacting families at the time that they are coming in for Medi-Cal or AFDC eligibility, to inform them about the program.

We have provided a dollar per eligible child to the schools to cover their administrative costs. In times of inflation, we understand that that's got to go up in the near future if we are going to cover their costs.

Our success rate has been relatively promising, over time. A couple

of years ago, we were screening on the average of 100,000 children a year. Next year, we expect to screen over 400,000 children, of which approximately 350,000 will be Medi-Cal eligible.

The school entrance requirement has been increasingly successful in meeting the requirements. Last year, approximately 67 percent of the children in public schools met the requirement of having an examination. Another 7 percent brought in waivers stating that, for religious or other reasons, their families declined to participate in the program.

As we start to look about where we're going, I think this is an interesting and critical time for the program. And as a matter of fact, if I were asked what are some of the big issues facing the California CHDP program, I would say that it is probably that we've come through a certain period of growth. We are about ready to have to change directions, even if it weren't for new penalty regulations and new CHAP legislation looming on the horizon. Part of this is what I call the critical volume. At 400,000 examinations per year, we have reached the point where we've got to develop more sophisticated approaches to handling the case management and the claims processing responsibilities.

We have, at this point, no automated case management systems in the State. In part, that's our own problem. HEW has told us that we must come up with a State EDP plan before any county can develop an automated case management system. And, unfortunately, in a Proposition 13 era, some of the counties have more staff to develop EDP systems than we do at the State level to develop an overall plan.

Nevertheless, many counties are at the point where they have to take staff off program responsibilities such as outreach, et cetera, in order to keep up with some of the case management activities. Also, at 400,000 claims a year, our largely manual claims processing operation had a huge backlog last fall and we've only recently dug out of the hole that we created there. So we are looking for resources there, too.

We've got to think about the future in some other ways. One is the issue of continuing care. Of the examinations that are done in California, 50 percent are now done by providers that we designate as continuing care providers. Nevertheless, there are some questions that remain around that. How do we know and how do we determine, and at what point should we be concerned about determining, whether a child falls out of a provider's care.

An informal study done a couple years ago in New York City showed that, in the inner city, many of the children in the neighborhood were known to at least three or more of the providers in the community. This might be a private physician; it might be a well-child clinic; it might be a hospital emergency room; or a hospital outpatient department. Nevertheless, if we assume that a child is in a provider's care, what is the point of contact or notification, or identification that the child no longer is under the care of that provider?

Another problem is case management. I think the basic question is,

what are we going to decide is case management? Again, referring back to my New York City experience, we had seven children and youth projects under Title V, that were in New York City. We started out thinking that they had developed case management systems and approaches in the '60s and that what we were doing was modeling after them.

New York City, in monitoring them, decided that they really had inadequate systems for determining whether children got to a source of diagnosis and treatment. So we continually ask ourselves, what is case management? When do we assume that the provider has met his responsibility? How much monitoring are we going to do to assure that it has been met?

Another problem that has been particular to California, and I don't know whether it has been a problem elsewhere, is the issue of developmental assessment. A couple of years ago when it looked like we would push to have a system of developmental assessment, there was great discussion that most of the approaches that were prevalent were disadvantageous to minority groups.

Beyond that, I would say that I think we've not yet seen a definitive approach that the physician and educational community can agree on. So that is another area where we're going to be looking to some Federal leadership, both in telling us when the problem is solved -- the problem of identifying the approach that is definitive in meeting needs -- and also to give us a hand in putting off the pressure if we haven't reached that point yet.

In closing, I'd like to say that we've really enjoyed some of our more recent interaction with the Feds, and I think that it has been a delightful change and refreshment in the last couple of years from the early days of the penalty, particularly 1975 and early 1976, when we were all suffering under the battle of, if you said anything to the Feds, it was sure to come back on your penalty assessment report. We've learned more about what our problems are. You've learned -- you Feds have learned that we do have something to say, and we love getting you out there and getting you involved in our issues. So I think we are really looking forward to working with you all as we try to go forward with the new changes.

MR. McKITTRICK: Good morning. Apparently, they feel that, in Pennsylvania, we are doing some things right, and maybe we're doing some things wrong.

We have questions about the whole EPSDT program, but because it's a law, we do it, and that's basically the size of it. But, you know, it's been called a tragic failure by Senator Kennedy, and you hear that Joseph Califano is concerned, almost as much as he is about smoking, about EPSDT. And there is a lighter side to the program.

This is a true story that was recounted by one of our providers: one of the tests that you probably have in many of your States is urinalysis. So the nurse takes the little boy and says, "Now you go into the room

there, and put it in the jar. Now, don't put it into the toilet, put it in the jar." So he says, "Yes, ma'am." So she waits, and she hears water running. And she says, "Oh, he's a very nice little boy; he's washed his hands after he's finished. That's very nice."

He comes out and he hands her a clean jar. And she says, "Well, what's this?" And he says, "Well, I didn't put it in the toilet, I put it down the sink, and then I washed out the jar." And she said, "No, no, that's not the idea. Please go back and fill this." So he was in there for about 10 to 15 minutes, and they were hearing nothing, and hearing nothing. Finally, he comes out and hands her an empty jar again, and he says, "Look, lady, you're going to have to get some other little boy to fill this jar, I just can't go anymore."

That's just one of the problems you find in implementing an EPSDT program. Basically, what we did in Pennsylvania is we sat down and said, what's this program mean? First of all, the initials don't say anything; they just say "EPSDT", which doesn't mean anything to anybody.

The program is required to cover everybody up until they are 21, so it's not really an early program; you can't say screening a 19-year old particularly early. What do you mean by "periodic"? People go on and off welfare. How many people stay on welfare for 21 years? So it is not really a periodic program.

Screening. What's screening? Well, the Feds said vision, hearing and dental, and the American Academy of Pediatrics said vision, hearing, dental, and 19 other things.

Diagnosis and treatment. Are they really separate? Is health care that undynamic? You know, diagnosis only today; no treatment. Medicine is not that clear-cut. But yet, you have a piece of legislation that is very clear-cut. You have to do this in 60 days; you've got to do this in 90 days; that sort of thing, and it's really a problem.

So we sat down and said, "What is the problem?" We decided the problem was one of organization. There is a medical care system out there. It might not be a well-developed system. It's sort of an anarchy, but it works.

So we decided to organize the health care system. Okay, that's one problem identified. The second problem is that you look at the legislation. You look at the regs and say, "How is this program different from medical assistance in general?" Aha! Provide and arrange for; that's the key here. You have to provide and arrange for the service. The difference isn't you have to outreach or you have to notify and all of that; that's some dream of a social worker.

What really is the question here is providing and arranging for the service. Now, the rest of the medical assistance program, you give people the card and you say, "Good luck, if you're sick."

In the screening program, we decided we were going to round up

doctors -- simple words -- we were going to recruit providers in the program. If we have to use that naughty word "outreach," we'll say we were out reaching providers.

We said, "How are we going to go about this in Pennsylvania?" Are we going to hire a large staff in the central office of the Welfare Department and the regional offices, and the county offices to go out and do this? We've never really dealt with providers in the field. And suppose the Feds change their mind later on and we don't need this program? We'd be stuck with the bureaucracy until they retire. You know how hard it is to get rid of people once you hire them.

So we decided that the best thing to do would be to hire contractors. We put out bids. We asked people to bid on managing providers into the program. To give them an incentive to do this, a real incentive, we didn't pay them on a cost reimbursement, we paid them on a per screen basis. We felt that there is a real correlation between how many screens are performed -- if you're going to get paid on that -- and how many providers you get into the program who are willing to see children on an ongoing basis?

We also brought in an advisory committee of leading pediatricians, family practice doctors, and osteopaths, et cetera, to advise the program on what a good package of tests would be, what a good form would be to collect this information, et cetera.

We sat down and said to the doctors, "What's your problem with the Pennsylvania Medical Assistance Program?" And they came back, and in crude words, we were cheap and we were slow. So we said, "What can we do about that in screening?" So we came up with a package fee under the Medical Assistance Program, that they found satisfactory. We paid $24 for a package of tests for a child over the age of 18 months. We paid $12.50 for a child between the ages of birth and 18 months.

They said, "Well, you're not so generous, but we can live with this." Okay, that's fine. The other thing about being slow is, one of the things the contractor had to do, in addition to recruiting the providers and showing them what the program was all about, was act as our billing agent for these providers. And by so doing, they were able to submit bills on a computer to the Department every month. We were able to pay the providers, oh, about 40 days or so, from the time they screened. The regular Medical Assistance Program takes considerably longer. So, even though we viewed EPSDT as not a separate program, not apart from Medicaid, but as just another Medicaid benefit, just like dentures are, something like that, we did set up a separate billing system which gave us not only some quality control monitoring capabilities over the screening program, but enabled us to pay the doctors faster.

How do you go about developing a system? Well, contractors sat down, the State sat down, the providers sat down, and we started, saying, "Well, in Pennsylvania, we're not in a wilderness." In fact, we have one of the largest medical complexes in the world in the Philadelphia area, and the Pittsburgh area is pretty well stocked. Even though we have the largest

rural population in the country, there are people who are going to doctors here and there; they are not just sitting home getting sick and doing nothing about it. They are going to p viders.

So the contractors went out and they talked to the various community groups; they talked to the local welfare agencies, and they said, "Who is seeing Medicaid kids? Where are they going?" We went around and we enrolled all of these providers. We enrolled private practitioners; we enrolled clinics; we enrolled children and youth programs. We went to providers who were seeing Headstart kids, and asked, "Would you be willing to see more Medicaid kids?"

And the contractor sat down with the provider, and said, "Look, this will not disrupt your practice; you can pay for the audiometer you don't have out of your fees because we'll show you an efficient way to see children that's fast, quick and humane. You'll get paid rather quickly, and you can make a little money on this program; not a lot, but you'll meet your costs, and if you do it right, you might come out ahead and pay for your audiometer in a reasonable amount of time."

That was one of our biggest drawbacks. Doctors didn't have audiometers.

"We want you to treat these children just like you would treat the average person off the street. We want you to do the program on them. If they have a problem, we want you to be the first source of treatment if the parent is willing to go to you as a provider. We also want you to be the first source of referral."

In the middle-class, if you go to the doctor and he says, "Well, I think you're going to have to go see an eye doctor," he doesn't send you out the door with the yellow pages. He tells you, "I have a colleague who would be willing to see you," and he might even have his nurse arrange the appointment for you right there, if you want to do that.

Well, we wanted the same type of treatment for the welfare child. We didn't feel that we should have a dual system or a separate program because we didn't see that as a goal of the program. The goal of the program was to get kids into a continuing system of health care.

We got the providers all lined up. We started out with about, oh, 15 or 20 providers, and now we are up to about 1100. In any given month, about 550 of them bill the program. We've had very few providers drop out over the last four years. The ones that have dropped out have dropped out for reasons such as death -- which we think is valid. They've dropped out because they've retired -- semi-valid. And they've dropped out because they've changed their modes of practice; they are no longer pediatricians; they decided to go into internal medicine or something like that.

I think, in the whole time I've been Director of the program, four years, I've gotten about three irate letters that told us the program was terrible, and this and that and the other thing. So we've really managed to do pretty well with the private provider.

We have not raised our fee in the last four years of the program. We still pay $24. In the beginning, there was some hue and outcry that this was kind of low, particularly from the providers in the larger areas. This has died off because they are finding that they are seeing kids on a regular basis; the kids are coming back for rescreens; the kids are coming in between to see them for ongoing care. The program is profitable, is reasonable, and can be handled in a way that won't disrupt their normal practice.

There was a lot of resistance, particularly in some of the rural communities that, "We don't want these people in our offices". And you start saying, "Well, who are these people? These people are your neighbors who have some hard luck for awhile, and get on and off of it; they are not some funny people we brought in to give to your office. They are your neighbors. And they don't act any different than anybody else. Your other clients arent going to be upset or disrupted." And they found this to be true.

Many providers started out their practices with the EPSDT program, and have kept the clients on when they went off welfare, and everything else, and it has worked out very well. We haven't had any complaints about "these people."

The biggest complaint we've had is the one about not showing up for appointments, broken appointments. And that, we feel, is a direct result of our outreach program, which we do because it is mandated under Federal law; we have to provide and arrange for the service.

One of the disagreements we have in Pennsylvania with the Federal legislation is that somehow or other, outreach is what makes the program work. If you stir up enough people, and tell enough people that they should have this service, and explain it to them, they'll all demand the service and, somehow or other, the supply side, the providers, will show up to meet that demand.

We don't think that, as a group, people on welfare are any less capable of determining what's best for their own health than any other group of Americans. And therefore, we keep stressing the supply side.

In the city of Philadelphia, we have an outreach contract that is very, very expensive compared to the rest of the program across the State, and yet of all the children seen in the screening program, only 30 percent of them come as a result of the outreach program. The other 70 percent, basically, are screened because they are already going to a provider; they've already established a relationship with that provider; they like going to that provider; and we've enrolled that provider into the program.

That is how we developed our system.

How did we make the system accountable? How did we figure out what's going on? Well, you do have to do a little bit of publicity about the program, inform people that it's available.

I separate informing from outreach. To me, outreach is when you take somebody by the hand and you take them into the doctor's office. And there were interest groups in Pennsylvania, particularly the Welfare Rights Organization that were advocating this type of approach. We felt, in Pennsylvania it was particularly paternalistic to do that. It doesn't do anything for people taking responsibility for their own health care and it creates an administrative nightmare to try to set that up. The bottom line, also, is that it is very expensive.

So what did we do? We had to publicize the program. Well, we didn't set up a special program. We told the county Board of Assistance offices, which is where people go in Pennsylvania to sign up for welfare, and where they find out about Medicaid and food stamps, and fuel stamps, and every other kind of benefit you can get under the Pennsyvania Welfare System. We told them you have to tell people this program is available. You have to tell them there are providers in the neighborhood who would be willing to take them. If they want, you have to set up an appointment for them but you should encourage them to make their own appointments.

However, to make sure that you're telling people about this program, we're going to put a performance quota on every one of the county boards. So I sat down in the central office, took out my pocket calculator; we took out the Medicaid eligibility file, which we had, that tells the number and the age of every child in every county in the State.

We sat down with the periodicity schedule, and we worked out a formula. And we said, in this county, if they are telling people this right, and we have enough providers there, we should screen, say, 80 kids a month. Every county got its quota. Some counties have a quota as low as 8 a month; some counties have a quota as high as 6,000 a month. It depends on the size of the county.

We used that as a yardstick. Nobody was going to get fired if they didn't meet it, but it works out as an accountability tool. The counties know where they stand. We introduced this program system in 1976. Without an additional expenditure of money, our screening figures jumped from 115,000 in 1975, to 175,000 in 1976. It was basically because the counties now knew what was expected of them.

We also put the providers on notice that we were watching how well they were doing at the referrals. We have a place on our screening document that says, "Referral not made. Please refer to the County Board" kind of thing. And there were certain providers that were just jotting that down on every child they saw. They were saying, well, he needs to see a dentist, but we didn't make the referral.

We went to these providers and told that, you know, if you don't want to do the follow-up treatment, and you don't want to do the referrals, then maybe you don't want to do the screening. You know, it's like taking the money and running. That's not good medicine. We didn't tell them that bluntly, but we told them that in so many words.

And it pays off. You can appeal to professional pride in providers.

They will respond to that. What you can't do with a provider, and a public provider, or a private provider is tell them how to run the show or tell them this is a worthwhile program, and this is the thing to do because, as it turns out, the screening concept itself is rather controversial in the medical community; it's not something that is done every day for the average middle-class person. Some people get it, but most people don't. They are wary of the medical assistance program, and the Medicaid program, in general. And to have some State bureaucracy coming in and saying, you have to do this for a kid, you get a negative approach. That's why, when we use the contractors, they fostered a positive approach. This is a program that is beneficial; this is a program that you can earn some money on; it won't make you go broke, and you'll be providing a service to the community.

It also turns out that many of the providers, who started doing this same type of practice for the welfare child in their practice, started giving the same type treatments to the non-welfare population. I had one provider in Allentown, which is not a real enlightened area; middle-class area, he objected to the program back in '74. You know, "I've been out of medical school for 20 years, and I don't need an audiometer. I can tell by looking at a kid whether he can hear or not." You know, the whole thing that doctors give you when they back up on their expertise.

And we said, "Well, that's fine, we respect your expertise. However, our State regs were recommended to us by other pediatricians; other doctors say you should use an audiometer. You know, we're not making this up, this is an established body, AAP thinks it is a good idea. What do you think of that? Use an audiometer. If you don't like it, drop out of the program." The doctors always have that option.

Well, he showed up at a meeting in 1976, and he said, "You know, I was very skeptical about the audiometer." He said, "Now, it turns out, I use it on all my patients and everybody loves it." And he said that it has worked out very well.

So, you know, this is the type of thing we do in Pennsylvania. We try to take an existing system, and we try to build on what's best. It's a lot easier to throw another log on the fire than to start a fire from scratch, and that was basically the approach we had in Pennsylvania. Go to where providers are, see who is seeing kids, get them to organize their mode of delivery around our preventive health care concept in EPSDT. Get them maybe to expand the number of welfare clients they see from a few token things, so they can say, "Oh, we do our bit for the community," to a reasonable amount of children they can see, that won't cost them a lot of money, won't disrupt their practice, will provide people with an ongoing system to keep going back to. We found that this has worked out. It has not been a disaster; it has not been something that's impossible.

Now, it's also not something that's that easy to do. I think I'm oversimplifying things a little bit. We've had a lot of resistance from different provider groups; we've had to go back and back. Our contractors have worked very hard at convincing them that it's worth coming into the program. What we use is not quite the hard sell, it's the continuous sell

approach. We used the same management technique on a doctor's group that anyone dealing with the doctors would use -- drug companies, Xerox, or IBM office equipment, or anything dealing with any kind of business.

We'd tell them what the program is about. That's the first sales pitch. We instruct them how the program can work for them. And then, continuously, month after month, we go back and check on that provider. "How are you doing? We see you're having a problem here. You know, we rejected all of the claims you sent in last month because you left this item off the screening form. You want to train your clerks to figure this out so they won't do this again. We see you're having problems with over-referrals for hearing. Let's look at your audiometer. Oh, look, it's out of whack. Let's straighten that out."

We give the doctors continuous monitoring and continuous feedback. Private industry has used this for years. When you are trying to compete with limited resources, you have to give this additional care. And it's not expensive. One of the things a doctor brought up here was that the program is expensive for the States. I sort of reject that out of hand. If you look at it by itself, it's expensive, but if you look at it compared to what you spend on the rest of your Medicaid program, it's a drop in the bucket.

In Pennsylvania, where we do all this, and we have a fairly expensive EPSDT program, we spend roughly, including treatment, outreach, administration, something around $13 million a year on EPSDT. That's only 1.3 percent of the total amount of money we spend on the whole Medicaid program, which is around a billion dollars. Comparatively speaking, it's a cheap program. It's not near as expensive as your hospital program for adults or your nursing home program, or anything else.

So to sit back and say, "Well, it's an expensive program, we should not get involved in it," is a mistake. However, what we need is some sensible, clear thinking on the national level as to what this program is supposed to mean. We recognize this in Pennsylvania, and I think all of the other States will agree with this. We don't need to change the initials from one set to another; we don't need to go into some kind of long drawn-out tracking system that guarantees that on every day, at any given time we can tell whether John Smith in Potter County has got his screen. We don't need to know that. We need to know that we've developed a system where the average person on welfare can go to a doctor, can get preventive health care services on a routine, regular basis, and can go back there for regular ongoing care.

I don't think you have to know every individual case. You don't have to take the case by case approach. I think that's been one of the mistakes in the program nationally and I hope that we're sort of easing our way out of that. And I hear people from the Federal government talking that way. I'd like to see us get out of that entirely and let every State develop its own and then go to the Feds and say, "This is what we're going to do, do you agree with us or not?" rather than the other way around.

However, we basically did that in Pennsylvania. We developed our own

plan. We were criticized. The program was quite controversial in the beginning. We were sued by a welfare rights group. It got a lot of national publicity. We were one of the first States penalized, all because we went our own way. So, you know, outreach is all right, but it is not the key to the program. The key to the program is the supply side.

And we harped on the supply side. We built our system and it has paid. We screened over 700,000 children in the last four years and the people basically are happy with it. WRO was one of our biggest critics because we didn't get the program off the ground on a timely basis and took us into court with a $12 million lawsuit. Now, when they meet with the Secretary of Welfare, they admit that it's a very fine program.

We've been talking a lot with the Federal government. They've been telling us our program has some nice elements. I can't recommend that every State can do what we do, but I do think you have to sit down and you have to think: what does your State need, where is your system in the scheme of things, what kind of medical care do you have there, how continuous and how comprehensive is it?

In Pennsylvania we had a big feud with the health department for a number of years. They wanted the program. But when you're sick, you don't go to the health department. You go to the public health nurse to get your immunizations; you might go to get your chest x-rayed, or something like that. But when you're sick, and it's 8:00 at night and you get sick, do you call the public health nurse? No, you don't, you go to a doctor.

That was the approach we wanted to take in this program; go to a doctor. If it is good enough for the middle-class, it is good enough for the lower class -- or the welfare class, whichever you want to call them. And we didn't want a poor man's medicine. I think that was our overriding concern.

By taking the approach we have, we've been very successful. Like I said, it's not going to be easy. You're going to have a lot of providers arguing with you. You're going to have a lot of resistance from social workers. I think that our second biggest resistance group was the social workers, saying, "Well, you know, you have to deal with individuals here; you're concerned about numbers and systems, and all that; we deal with the individual."

And I said, "Well, yes, while you are dealing with one individual, ten individuals are standing around out there waiting. So let's deal with a lot of individuals. Let's set up a system so you won't have to deal with the individual."

And you get into job protection, and all that kind of nonsense, but, like any kind of progress, there are going to be casualties, and one of the casualties is you don't need as many social workers if you develop a system where people can go to the doctor on their own because they know it's there. And if they don't know it's there, and it's not really there,

or it is just a token effort by the provider community, all of the social workers in the world, and all of the outreach efforts in the world aren't going to get people to go and continue to use that provider.

So if you don't deal with your provider, whether it's private providers, or clinics, or public health services that offer comprehensive care, you're not going to get anywhere, and the program is not going to get anywhere.

And, you know, we'll still be talking about this five years from now.

I think what is adaptable from one State to another is taking an approach, an organizational managerial approach, which I think is a good counter argument to the case management, case by case social work, social welfare approach.

And I will say this -- and this is the classical cliche -- some of my best friends are social workers.

QUESTIONS AND ANSWERS

QUESTION: How do you pay for your follow-up care? Do you have a special rate for that? And do you run it through the same claims processing system?

MR. McKITTRICK: Okay. No, we don't. That's been one of the drawbacks. Back in 1972-1973, when the program was being developed, we had originally thought that the legendary MMIS kind of program would be available in Pennsylvania. To this date, we are still working on it. Therefore, you get your $24 up front for your screen. If on the same day, or the same week, you do a treatment under the regular medical assistance program, you bill through -- as Senator Weikert described it -- our "stone age manual payment system," and you get paid maybe four months later.

However, we have found, in studies that were done independently, that despite this, the doctors are willing to put up with that lousy payment system because we request them to do that, so we get about 87 percent of our kids followed up anyhow. But, right now, we don't have the tie-in. On our MMIS planning, we have an EPSDT module that will automatically tie that together and the doctor will be paid on about a two-week time frame for everything, but we don't have it right now.

QUESTION: What do you pay for your follow up?

MR. McKITTRICK: Standard office visit rate for a general practitioner is $6. Our specialty rate, if you're a specialist and you're in the bigtime, is $10. So it's not all that attractive. However, the screening, front-end rate, of $24 sort of offsets that. If the doctor sees the child -- and most of the children don't require heavy duty treatment, they require some minor corrective-type of thing -- the doctor is really getting $30 for the child for that short series of visits, so it's not all that uneconomic.

QUESTION: Let me ask you one other question. The biggest storm of protest I've ever had since I've been in the program has been when we tried to get our physicians to sign the most innocuous provider agreement you can imagine. CHAP proposes to have provider agreements that they will go on and provide the services that your providers are already giving. What do you think would happen to your providers if they were required to sign an agreement to do what they are already doing?

MR. McKITTRICK: Okay, I'm speaking not necessarily for Governor Thornberg and the State of Pennsylvania, I'm speaking for myself here, but I think that if, on the individual claim, the provider signs that says he's obeying the law, and all of that sort of thing, which we have, that's fine, but to have him sign an agreement ahead of time, I think subjugates his professionalism, is an affront to his oath and all that sort of thing, and I don't agree with it. I think it is a standard bureaucratic ploy. Some would sign and some wouldn't.

QUESTION: I'm a provider. I would have to disagree with you on that. I'm a practicing pediatrician and I think that there is another approach you can take and that is that providers listen to other providers. We have been working with the American Academy of Pediatrics on what is continuing care in the CHAP legislation. And from what I'm hearing from the Academy is that they are all very happy about it.

I think if we're going to pay people to do certain things, I don't think it is unreasonable to ask them to sign something. I signed a provider agreement to become a Medicaid provider. I don't think what we're talking about with continuing care is something that we thought up from the moon. What we're thinking about is that, okay, if I have a kid that needs vision, I'm going to call up one of my colleagues and, you know, say, "Look, I have a kid here who needs eyeglasses". This is not something that just whacko-way-out, and I think it is the way it is approached.

Let me just speak to one other thing. I was talking to somebody about lead-based screening, and somebody said, "Well, maybe we ought to just tell these providers that they have to do the EP test on everybody." I said, "Look, you know, there is an article coming out in the New England Journal in a couple of weeks which speaks to the problem of lead-base paint, low lead levels causing neurological defects later on in life." Instead of saying, "Here come the Feds, here comes the State, we're going to tell you how to practice medicine," get one of their colleagues and say, "Hey, this is the problem. Don't you think that you ought to screen for lead levels between the age one and a half years and four years when these kids are picking up lead chips?"

QUESTION: What you think and what the practicing pediatrician thinks -- and remember that the majority of well-child care is given by family practitioners, not pediatricians -- are two different things.

And when you say you've got to sign an agreement for one segment of your practice, you are insinuating that you're not taking good care of the other segment of your practice. And there is no simple way to approach that.

MS. LYMAN: New York started out with a very legalese-looking document that started out with about 50 different whereases. That didn't meet with much success. We then went to a more informal letter of agreement and used it as a document to spell out both what the providers' responsibilities were and what the EPSDT programs' responsibilities were.

The providers were far more accepting of a document that spelled out some responsibilities for the administering agency in addition to responsibilities for the provider.

QUESTION: Has any thought been given by HCFA toward capitalizing or utilizing school health as one of the many packages of health services for kids out there that we aren't now tapping?

DR. TIERNEY: Yes, absolutely. We are working with the Office of Education. And what we'd like to do, at least on a pilot basis, is to pick out maybe ten States, State boards of education, relating to State Medicaid agencies, and to utilize various modes of providing health services to those kids.

Jim has a small program in the State of Pennsylvania utilizing private providers who provide care in the schools. The State of Louisiana, for example, has a program in which it utilizes nurse practitioners who then refer problems to the physician community, either the public health physicians or the private physicians.

What we'd like to do is get some funds from R&D to expand this. Yes, I think that this is one way that we do have to go. Supposedly, you've got a captive population. A lot of the kids are out doing their thing outside of school -- truancy -- and they sometimes show up, sometimes they don't, but we are trying to get school health programs going. The Office of Education doesn't want to do any more than ten States right now because they are not sure that they can bring some of the school districts on board; they are really quite autonomous. They make most other Federal government programs look like it is very tight control. But we are going to try to work on that.

QUESTION: I have a question to direct to both of the States. You've talked a bit about getting people into screening, and I don't think you've talked very specifically about when somebody is in screening and you've found problems, what techniques you're using to follow-up.

Do either of you feel you have an effective system to follow-up on abnormal conditions discovered during screening and, if so, how does it work?

MR. McKITTRICK: Yes, we feel we have a very effective one in Pennsylvania. In fact, your School of Public Health, University of Texas at San Antonio did a study of nine States, a couple of years ago, and Pennsylvania's EPSDT program had an 87 percent follow-up, which was almost incredible for this type of program.

Basically, the way it works in our program is that every provider who screens also has to be willing to do treatment, if it's within the provider's capability, and is told that in the letter when the provider is enrolled into the screening program. The provider should be the first source of referrals. And if that isn't possible, the child is referred to the county Board of Assistance.

So what happens is, on the screening form itself, if a referral is indicated, the doctor writes down the type of problem and whether referral was indicated, whether an appointment should be made immediately -- it's an emergency -- or, it could have a time frame on it.

This report goes to the contractor who reviews the screens and prepares the screening bills and all for the provider, then makes a report that goes to the county Board of Assistance office. The report contains the name of every child who was referred that month at a screening site, and indicates the status of the referral, whether it was immediate or emergency, and whether an appointment has been made or the county board will have to make an appointment. Then we have a column called "30, 60, 90 days, 90 days plus." The county board gets copies of this printout. They contact the family or the provider, whoever they can get in touch with, and find out whether the child has actually showed up for follow-up care. If not, they will arrange for an appointment for follow-up care, and then they remove that child's name from the list.

If they don't remove that child's name from the list, the name appears next month and an asterisk moves over and says, "It's been 60 days now, do something," and then 90 days, and then it's flagged. And we find that that has worked out very well. The counties think it is a good tool, but again, the biggest success in our program has been that providers themselves, who are doing the care, are not just screening providers.

The majority of the things you find in a screening can be handled by a general practice physician except for dentistry or vision, but most of the other problems you find -- upper respiratory infections, skin rashes, updating immunizations, that sort of thing -- can all be done by the screening provider. So most of our screening is initiated either on the day of screen, or within a week of the screen, by the same provider.

So we don't really have a big problem with follow-up.

MS. LYMAN: I think the experience in California is somewhat along the same lines. The screening form calls for differentiation by the provider as to whether he is going to take responsibility for the follow-up. If he is a continuing care provider, that's assumed. And also to differentiate as to whether it's a significant or a routine condition that needs follow-up.

Probably our success measures are more due to constant informal communication between the public health nurses and the county health departments, and the providers in the counties than to anything more magical than that, but there are very close ties and the providers are continuously given reminders and given opportunities to contact the county

health departments, so there is a lot of back and forth exchange between our providers and the public health nurses at all times.

QUESTION: I'm wondering if you have any particular problem with broken appointments and how you handle that or if you have any special program for handling it.

MR. McKITTRICK: Yes, we have a major problem with that, particularly in the urban areas where we make appointments. Basically, we go back and remake the appointment. We've tried double-booking, you know; in other words, if on the average two people don't show up for every one that does, we'll make three appointments for the same time and hope that that holds true where we make appointments.

In the City of Pittsburgh, under contract, we have mini-vans that actually go to the people's houses, pick them up and drive them to the provider. In spite of that, we still have a 35 percent no-show rate. You know, the driver goes up to the door and says, "We're here to take you to the doctor." And they'll say, "'Days of our Lives' is on, we can't go right now."

And we really don't have any answer. You know, we've looked into it. We think that in rural areas, people will go for health care because if they don't go now, when will they go. In the urban areas, they figure, well, if we don't go today, the doctor is always going to be there, so what's the hassle?

And I don't have a cure for it.

MS. LYMAN: You don't know a broken visit problem until you've dealt with New York City where, overall, the broken visit rate for any Medicaid appointment is 50 percent, and for EPSDT, it's 80 percent. We never found any particularly good answers, but they are still trying.

QUESTION: Dr. Tierney, you spoke about equivalent care and said that you were making changes in that when referrals were made, such as to a dentist, they didn't have to be on the same ground. I don't understand how that is different than what we're doing now. Could you expand on that?

DR. TIERNEY: Well, I think that there has been a confusion, at best, from the Federal level about what is equivalent care. And there has been some -- well, let's say that because of the lack of saying what equivalent care was, there has been some misinterpretation both on the Federal level and, to some extent, on the State level.

Now, obviously, you know, I'm saying what you're doing, but there are some people who have been saying "Look, if a provider can't provide medical care, dental care, vision, hearing aids, everything all in one place, they are obviously not providing equivalent care."

One State, for example, said, you know, "Look, if the provider can't provide transportation and taxi service, then it isn't equivalent care."

That is really an extreme, but all we're saying is, you know, how does the system work, what's reasonable? If the physician is providing this and can refer to an opthamologist or an optometrist to get the kid eyeglasses, then he doesn't have to have an opthamologist on board.

At the beginning of the program, oftentimes, some people, because of misinterpretation, have said, "You know, look, we can't use the private sector; we can't use the Title V clinics because they don't have an opthamologist on board." That's all we're saying, that you're doing it correctly. What we want to do is finally get this whole thing cleared up so there aren't these misconceptions of what we mean.

QUESTION: I'm somewhat troubled by the obvious dichotomy between yesterday's presentations and today's. Yesterday, we were talking about an integration of activities between Medicare and Medicaid; billing forms, terminology, et cetera, et cetera. Today, we are talking about splitting out a piece of the Medicaid program to treat it separately so that it won't be integrated with the rest.

There is certainly a substantial amount of difference between the process for receiving care and billing for it, and the reporting of what was done as a result of that particular visit. And incorporating the medical report and actions with the billing form is certainly, to my way of thinking, a step in the wrong direction because you end up with a much more complicated system that really destroys the viability of pieces.

You've got a pattern already for a similar type of activity within the Social Security Administration in the disability evaluation function for Title II and Title XVI where you have a medical report and a bill for that report which, to the best of my knowledge, in no State are combined into one document.

DR. TIERNEY: On the other hand, I've been hearing States saying, "Look, we need a form such that we know what's going on." This does -- you're right, it does run somewhat counter to the single claims form for Medicare and Medicaid. The problem is that this is a different program. This is a program in which you're supposed to provide and arrange for treatment unlike what most insurance plans do; I mean, including Blue Cross and Blue Shield. What we are trying to do, then, is rather than having the social worker at all times shlepping around behind every single kid, on a kid-by-kid basis, is to try to find the kid that isn't getting that.

And I don't know any more efficient way -- and maybe somebody can help me on this -- than having the burden placed on the provider to tell you what care this person is getting. One of the problems I'm hearing all over, from all of the States is, we just don't know; the doctors write in illegible handwriting, and they come in, you know, and you don't know what we're getting.

We want to have it fairly simple.

I agree with you, there is a dichotomy there, but it's a program that is different from simply a third-party payor.

STATE AGENCY INTERFACE WITH FRAUD CONTROL UNITS

Panel Participants:

Lawrence Lippe, Asst. Inspector General for Investigations, Office of Inspector General, HEW

Jim Patton, Program Integrity, HCFA

Joseph Piazza, Asst. Director
Program Integrity, NJ Medicaid Program

Charles J. Hynes, Special Prosecutor
NY Nursing Homes and Hospitals

MR. LIPPE: One of the most important issues that we've been addressing ever since the Inspector General's Office became operative two years ago, is to assist in the careful balancing of the need to improve the day-to-day programmatic responsibilities of the single State agencies through the various departmental mechanisms, give whatever help and advice we can in those areas, and balance that with the growing concerns and recognition that there still is an alarming incidence of fraud and abuse in connection with the Medicaid program, albeit involving only a minority of the many providers.

We not only have to balance the needs to run the program from a programmatic standpoint, and all the quality control and management issues that are involved in that, but we have to balance those agency needs, which are very real and significant, with the coming on the scene of a separate and distinct group of units which are now located in twenty-three of the States, namely, the Fraud Control Unit.

MR. PIAZZA: One of the main reasons that New Jersey was asked to share some of its philosophies and processes with you today is that, for several years prior to the enactment of Public Law 95-142, New Jersey had in place a formal agreement and, I think, a well-constructed working relationship with the Fraud Control Unit in New Jersey.

I believe that we have been highly successful in our efforts. I think that one of our reasons that we are as successful as we think we are, is that we continually look for new methodologies and techniques to improve upon our programs.

Particularly, we look to new innovative computer technology to help identify and ferret out potential frauds, abuses, and wastes in the Medicaid program.

I would like to address three basic issues: first, some of our perceptions as to the nature of program vulnerability in Medicaid; secondly, our perspective of what program integrity is; and third, the interface between the fraud control unit and the program integrity unit in the single State agency.

First, let me say, that the New Jersey program will expend somewhere in the area of $550 million this year for Medicaid services.

$550 million is a drop in the bucket in New York, but to us in New Jersey, this certainly represents a significant investment in taxpayers' dollars, and obviously an investment which must be aggressively protected from any improper diversion from its intended use.

So, when we are looking at this improper diversion, and all of those possibilities, we have to look at the vulnerability of the Medicaid program and we ask the question, how vulnerable is the program to fraud and abuse.

When we think about that, we answer it in a couple of different ways, at least we do in New Jersey. First, we recognize that Medicaid is one

component of that larger complex medical care delivery system, and therefore, any anomalies or causes in that larger system which give rise to fraud and abuse, obviously will give rise to fraud and abuse in the Medicaid program.

Just a couple of examples. Greed certainly is not unique to Medicaid but is systemic; also, the fear of malpractice, which gives rise to the generation of unnecessary medical services and tests. These kinds of things are pervasive in the medical care system itself, and obviously impact upon Medicaid.

However, deeper analysis would indicate that there are other factors rather somewhat unique to the Medicaid program itself, which perhaps create a greater potential for fraud and abuse in the Medicaid program.

I'd like to mention just a few of these. I don't intend to editorialize on any of these or address the merits, or the rightness or wrongness of the specific issues. All I'm saying is that, in our experience, we have identified this particular area of conduct or process as being one which gives rise to or, in fact, nurtures fraud, abuse, or waste in the Medicaid program.

Very typically, Medicaid programs have extremely low ambulatory fees, particularly physician fees. It is not atypical to find some States providing 50 to 60 percent of usual and customary fees. I'm not saying, in any way, that usual and customary is a proper fee. All that I am saying is that the perception of the provider in a situation where he is being given 50 percent of usual and customary, that he just may be tempted to increase some of his profits. That is just one underlying cause, kind of unique to the Medicaid program in the sense that it causes or helps nurture abuse in the program.

Conversely, you may have a situation where a fee is too high, strangely enough. Back in 1975, we had a fee structure for labs that had been developed a number of years before. At the time these structures were developed, we, for whatever reason, used prices of the old MA and PA bench-testing procedures. As we all know, bench-testing is very laborious, very costly.

For years that went by, we really didn't give much thought to what was happening in the area of automated lab testing. In fact, automated lab testing was, in a sense, making much of the bench-testing obsolete and certainly driving the cost way down.

The result was we had extreme fat in that reimbursement at the laboratories. That fat, in fact, caused the rebate kickback scandals in 1975. There was just simply too much money in that fee structure and it was too much of an inducement on the part of those who would attempt to abuse the system, to use that money -- kickbacks and all kinds of other strange devices. That's a correllary to having too low fee structures.

The next one is a kind of a sensitive area -- and, again, I'm not intending to editorialize. All I'm saying is, as we know, all mandatory

services and, in most States, or at least in New Jersey, all of the optional services are provided absolutely free of charge to the recipients.

Now, for some recipients, this lack of the financial incentive not to disabuse the program is simply absent. Further, I think there is a second point to be made: where there is no financial incentive, I think the recipient tends to ignore, or turn the other way when they see the provider abusing the program as well.

Signing multiple claim forms, being brought back more often than necessary, bringing your children to the office, not to see the doctor, but because one other child was going and suddenly the patient is signing claim forms for all the children, this kind of thing. There is no incentive not to disabuse the program.

This takes me back to our friends, the computers. Computers are extremely useful in helping to identify potential fraud, abuse, and waste in the program. I would just like to throw out a couple of caveats. First, when you think about it, the individuals, particularly in Medicaid programs, who are responsible for inputing the data -- the keypunchers, the eligibility workers, the intake workers -- are the lowest paid people in the system. What that means to me is, you generally don't get the quality person that would give rise to a much cleaner data base, more efficient system. I think what you end up with is a kind of garbage in, garbage out situation if you don't control it. We have a pretty good handle on that in New Jersey. Our claims processing is done by contractors and we think we have solved that problem quite nicely. However, I think it is a factor in the other States.

The second thing I want to say about computers is, and it applies to MMIS as well, exception reports are based on this notion of norms and standard deviations. Well, that's okay as far as it goes. Except if you're marginally stealing from the system, if you're not one, two, or three standard deviations from the norm, there is no way you're going to except out. And, if you know anything about statistics, two standard deviations from the norm is a hell of a long way from the norm in terms of generating an exception report.

I think one of my fears is having ten thousand providers, each stealing one hundred dollars a year, rather than one guy trying to get away with a million; you know you are going to catch him. But there are a lot of big dollars going out with marginally abusive providers of services.

I've got to say something about inefficient claims processing as well. I think many States, in spite of Federal regulations requiring certain turn-around time in terms of claims payment, have not attained the goals set out by those regulations. And obviously, this causes cash flow problems. When an individual has a cash flow problem, he has some incentive to do some other things with his system.

Also, I think many States lack sophisticated prepayment screens. I

think this is where a lot of big dollars really are -- in developing a set of highly sophisticated prepayment claim screens, screens which will reject claims that ought not be paid, yet promptly pay those which are valid.

Next point, legislation. I think this came up in one of our sessions. The Medicaid program has an identity crisis. Is it a welfare-related program, is it a health-related program, is it part of both? And there is some debate. I think some legislators perceive it as a welfare-related program. And I know some States, because of that, have had a lot of trouble getting the necessary funding for staffing, particularly Program Integrity service-type staffs. That, obviously, is an underlying cause which would give rise to, and further nurture, abuse in the Medicaid program.

I think you will hear Thursday, one recommendation that the State Medicaid Directors will make, for increased Federal matching for the Program Integrity Research Units. And I will leave that resolution until Thursday, the day of its report.

There are some Federal regulations which cause some problems in the Medicaid program. The one I have in mind now is freedom of choice. I'm not disagreeing with freedom of choice, but, freedom of choice is broadly interpreted to mean States cannot go out on competitive bid, for example, for lab services. As a matter of fact, the Federal government, as a friend of the court, filed a brief, clearly stating that freedom of choice would preclude a State from going out on a competitive bid basis for such services as lab services. In that brief, they indicated, in my view, that in fact, freedom of choice has no application in the area of lab services. It simply doesn't exist on the part of the recipient.

The last thing I want to mention is institutional reimbursement. Institutional reimbursement, by statute and regulation, is required to be made on a reasonable cost related basis. And I'm not addressing myself to the merits of that. All I'm suggesting is, at least in our State, over 60 percent or so of the Medicaid expenditure goes towards the institutional care; leaving one-third for all other services in the program that takes us back to the first problem of low ambulatory fees, so we have a cycle there.

There are other examples that I could mention, but I think the point is, if it's really effective, an anti-fraud and abuse and waste program must go beyond the identification of potentially fraudulant and abusive recipients and providers of services.

The program must develop a coordinated system to identify and eliminate all causes which give rise to improper diversion of Medicaid funds. Program Integrity then, at least as we perceive it in New Jersey, is more than a surveillance and utilization review function. In a sense it's a coordinated cost control, and cost efficient, approach to program management.

Serving as the catalyst, these 1975 lab investigations and findings brought about a new awareness of the nature and significance of the concept of Program Integrity. Consequently, the Office of Program Integrity Administration was established in mid 1975 by then Director Gerry Reilly. This office has continued to develop with the strong support of Director Tom Russo.

I'm not going to go into the details of the reorganization, except to say that in my view, one of the most significant changes that was made, was that little SUR's unit that we had in 1975 was reorganized in such a way and elevated to the status of one of the four major component units in the Medicaid program in the State of New Jersey.

All the units, with the exception of one, have as supervisor and assistant director of the Medicaid program. I think the significance of that is that the change placed the office in a position to propose and implement policy at the highest levels of the Medicaid program.

Lastly, there is one thing I want to stress also. Program Integrity in New Jersey is not only the responsibility of the Office of Program Integrity Administration. Program integrity is everybody's responsibility in the New Jersey Medicaid program, including the contractors. And, so, what we have is a well coordinated set of interfaces and agreements between all units and the contractors in New Jersey with the Office of Program Integrity Administration serving as central focus for these activities. In great measure, that coordinated effort between all parties and construing program integrity in the broad sense has led to much of our success.

The last area I would like to talk about will be the interface with the so-called fraud control units. At the same time that we were upgrading our Office of Program Integrity Administration in 1975, the Office of the Attorney General in the State of New Jersey also became acutely aware of the need to expand operations in the area of Medicaid investigation and prosecutions. And as a consequence, a Medicaid investigation unit was developed and upgraded at that time.

At the present time, we have a system, which can really serve as a model system in the sense of a relationship based on cooperation, trust, and confidence. And I'm not trying to suggest that what we have in New Jersey could work in your State. It may or may not. It has worked in our State. The foundation of the relationship is based on mutual cooperation, trust, and confidence. It's based on formal as well as informal arrangements. We have very lengthy contracts, which very clearly set out respective duties, responsibilities, criteria for referral of cases, turn-around time, and so forth.

Also, you obviously cannot run a day-to-day operation such as, review analysis investigation under strict terms of formal agreement. And because of the confidence, trust, and cooperation that we have, we are allowed a great degree of informality in the operation, which really makes it work very well.

I would just like to run through some of the advantages of having this kind of a relationship. First, obviously, each agency can establish its case priorities. It certainly minimizes duplication of effort.

Very frequently, our people are called upon by the fraud control unit folks to testify at their trials. We have found that this knowledge that we have of one another and this relationship with one another has the effect of expediting pre-trial work, as well as enhancing the trial case presentation itself.

One other area I would like to touch on here is a public relations aspect of this kind of a relationship. Under P.L. 95-142 and, hopefully, with this good relationship between the two agencies, the number of indictments, prosecutions, and convictions for Medicaid fraud should increase. It's a double-edged sword. If the number of convictions increases, and nothing else is said about it, you may have a situation of the public perceiving the program as being one rampant with fraud. And I think that will have negative impact on the program.

Secondly, you might find the legislature believing that the prosecutor really is the only person interested in or having anything to do with Medicaid fraud. Or you can develop a good relationship between your State agency and the prosecutor. The prosecutor can serve as the advocate of the single State agency. He can present the State agency's role and responsibility in the overall anti-fraud and abuse program. In other words, give it its gold star. It is very important that the program integrity or SURs units have a sense of identity, or it's not going to work.

Also, I think the prosecutor would be in a position to present to the public and to the legislature the precise, as best can be determined, nature and scope of the fraud picture in the State. Not blow it way out of proportion, but put it in its proper perspective.

Obviously a relationship of cooperation and trust, such as we have, has great benefit in terms of mutual training programs, which is needed. When we first came into operation, some of our folks didn't know evidence from a pickle. And, if you're going to make a case, a criminal case, you have to have clear chain of evidence, you have to have clear regulations. Many Medicaid programs either have regulations which are non-existent, or vague or ambiguous, and in that context any kind of suspension or recovery of dollars or prosecution is virtually impossible.

Lastly, as great as a relationship is, you are going to have problems, and serious problems, from time to time. And the only way that you are going to solve those problems is to have a good working relationship between these two agencies.

In conclusion, we believe the best way to eliminate fraud and abuse and waste in the Medicaid program is to establish strong and agressive units in the Medicaid agency and the fraud control unit. And thereafter establish well coordinated working relationships with all other appropriate agencies involved, including the U. S. Attorney, various boards of

medical examiners, or any other agencies or entities in your State or Federal government that have an interest in Medicaid fraud, abuse and waste.

In this way we can effectively impact upon what is one of this country's most costly and improper diversions of tax dollars, dollars intended to provide quality medical care for those individuals in our society in greatest need.

MR. PATTON: The fraud control units came into existence because the Congress, after months of deliberation, concluded that control of provider fraud in the Medicaid program could best be assured by having independent investigative and prosecutal units devoting their attention exclusively to health provider fraud.

The result of those deliberations was the passage of section 17 of Public Law 95-142, which created what we now refer to as Medicaid fraud control units. It should be mentioned that a member of our panel, Joe Hynes, probably more than any other single individual was responsible for promoting and ultimately securing passage of this legislation. His record of achievement in New York State in the years and months preceding passage of section 17, convinced the Congress that the New York model was one that should be encouraged for the rest of the nation.

Since passage of this legislation, some 23 fraud units, in States representing 73% of Medicaid expenditures have been certified. And they are now vigorously pursuing the investigation and prosecution of Medicaid fraud.

We believe that the number of ultimate indictments and convictions that will come about as a result of fraud control unit activities, will confirm the wisdom of the decision to provide the expanded Federal funding for these activities.

We, in the Office of Program Integrity, working with the Inspector General, are doing as much as we can to foster the development and ensure the success of Medicaid fraud control units. We believe that the added emphasis and attention given to the problems of Medicaid provider fraud through the activities of the fraud control units is essential in promoting the integrity of, and restoring public confidence in, the Medicaid program.

The Congress, in passing the section 17 statute, limited the fraud control unit to investigating and prosecuting health provider fraud. There is no reference in the statute to detect. It appears clear from the reading of the hearings transcripts, that the intent on Congress was to continue the primary responsibility for detecting provider fraud with the State Medicaid agencies.

There is a natural flow in the order of health claims processing -- whether you are talking about Medicare, Medicaid, or private health insurance -- which provides that those responsible for claims processing are in the best position to discover situations which may indicate at-

tempts to defraud.

However, it is apparent that, in order for fraud control units to meet their responsibilities successfully, the State Medicaid agencies and their contractors must be active in business of detecting situations of potential health provider fraud.

If, in fact, cases are not identified, fraud control units will not have sufficient work on high prospect cases to support a level of activity consistent with the scope of the problems State-by-State.

Detecting provider fraud comes about primarily as a result of applying techniques to assure the correctness of program payments. Any health claims payment operation will have, as a part of that process, techniques built in to assure that: the services billed for are rendered; that the services are medically required; and that the reimbursement levels are appropriate.

There are a variety of techniques employed to meet this responsibility: One, pre-payment utilization, reimbursement, and duplicate payment screens; two, post-payment screens with associated field audits or professional medical review, which identify providers who may be abusing the program; three, fiscal audits on institutional providers reimbursed on a cost or cost-related basis; four, reviews performed by State agency personnel to continue provider certification or to measure appropriate levels of care (accomplished through a medical review); five, complaints generated from EOB's, or received otherwise from concerned taxpayers; and, six, PSRO reviews to assure appropriate admission and length of stays.

None of the techniques are designed specifically and exclusively to detect health provider fraud, but any one of them can point up a potential problem which, if fully investigated, could establish a willful intent to misrepresent services.

The key is for the State agency personnel to be sensitive to the possibility of fraud and to bring those possibilities to the attention of authorities responsible for the investigation and prosecution. This can happen only if there are clear lines of communication between those in the State responsible for fraud control.

In Program Integrity, one of our main goals is to make certain that health providers abusing or defrauding the Medicare or Medicaid program are caught, stopped, and punished. Coupled with that goal, the current concern that instances of potential fraud should be detected and referred to fraud control units. Let me mention two activities that the Office of Program Integrity is doing.

First, each Program Integrity Regional Office Director has been instructed to arrange for visits along with Medicaid Bureau staff to conduct special reviews in each State where there is a certified Fraud Control Unit.

These reviews will be coordinated with the regional DHEW investiga-

tive personnel, who may, in some instances, also participate in the review. These reviews will have five objectives.

One, determine, from the fraud control unit perspective, the relative strength and weaknesses on the part of the State agency in identifying situations of potential provider fraud.

Two, determine, from the State Medicaid agency perspective, where their systems of abuse control and fraud identification are woking well, where some improvement is needed, and what can be done to strengthen existing approaches or design new techniques.

Three, perform an analysis of existing State capability, particularly in the SURS area and through the audit process to identify fraud and deal with abuse.

Four, get appropriate State Medicaid agency and fraud control unit personnel together to discuss existing communication and coordination procedures, and promote a model agreement which we have developed when problems exist.

Five, prepare a report articulating the existing problems recommending steps which could be taken to improve communications.

These reviews will be conducted over the next four weeks. OPI will prepare a report by the end of May for Mr. Schaeffer and the Secretary, based on the results of these reviews.

The information will be used to influence Federal policy in the area of fraud and abuse control to communicate that those committees in Congress who have oversight or legislative responsibility in this area, and to serve as a baseline against which to measure progress State-by-State in this area.

Program validation is the second activity that the Office of Program Integrity is involved in that has a direct bearing on Medicaid fraud and abuse control and the issue of fraud control unit and State aid relationship.

Program validation is a multi-facet approach geared towards both discovering health providers who may be defrauding or abusing the program, and also determining policy or procedure weaknesses, which may be contributing to erroneous expenditures. We are, and will be, using Medicare and Medicaid data bases to select providers who are statistically abberrant.

MR. LOWE: I don't have to tell you that fraud and abuse is a current hot item.

It's become a very fashionable thing. Unfortunately, the criminal justice system, and indeed, the other systems throughout our governments, federal and local, have far too long kept white collar crime on the back burner.

We have failed to perceive the corrosive effect, the cancerous effect, of white collar crime, and we, frankly, have simply never addressed it. It has become fashionable now because, like anything else, when there is something that becomes so explosive that we now must recognize it, we commit our resources to it and our energies to it.

But too long we have addressed ourselves to the street criminal, violent crime. I can understand that. I was a prosecutor for 12 years before I came here, and a prosecutor's office must address itself to violent crime. Indeed, if an individual cannot be safe to walk the streets without being mugged or raped or robbed or killed, then the whole pattern of society begins to have a corrosive effect.

But, the white collar crime and the white collar criminal rapes with equal lust, and robs and mugs with equal violence, though it may be subtle in its nature.

And, indeed, the white collar criminal kills, because the white collar crimes cut the heart out of the objectives of our social programs. Unfortunately, we catch the white collar criminals and we treat them differently. The inequities in our system go from top to bottom. We even dress up the white collar criminals.

I mean, we call them white collar criminals. Violent persons are called street criminals. Again, the effect is to suggest that they are less than honorable than their white collar counterparts.

It is my opinion that white collar criminals are far more reprehensible. Indeed, they don't have the justification, if there is ever a justification for the commission of a crime. They don't have the justification of the person who does not come from a well-to-do area. They have a profession. They cannot use any of these things to justify why they have entered into the kind of activity that they have been caught doing. Street criminals -- you know the knife, the gun, the fist, the stick are their tools. I am not applauding, I'm just simply reciting a fact. Those tools are what's available -- he hustles, the ability to survive. The pen, the brain, collusion, the scheme -- those are the tools of the upper echelon of our society who embarks upon this kind of career.

And as I said, it takes a major scandal just as the nursing home scandal in New York, and New Jersey, for there to be a response. In New York's case, the response was the appointment of Joe Hines, a special prosecutor for nursing homes. I guess the Federal government's response was to Joe's success. That response came in the form of creating legislation -- section 17 fraud control units.

The Inspector General's office has now assumed the responsibility for the overseeing of these units. And I think that is very significant. And I think that it is probably a very important situation that has recently developed.

We are in the business of controlling fraud, abuse, and corruption. We view these units as extensions of the Inspector General. There are 23

now. I don't know how many will ultimately be established. Extensions of the IG, and they are, in effect, probably more powerful then we are because they not only have the investigative ability and the investigative authority, but they have the prosecutor authority because they cannot only investigate and identify, but they can take them and walk them into court and hopefully nail them to the cross.

The purpose of this session is to discuss the interface between the State agencies and the section 17 fraud control unit. It seems to me if this is going to succeed and if we are going to achieve the results which we set out to achieve, there has to be a cooperative effort between all of those, either individuals or agencies involved.

The plain fact is, that the kind of relationship which is necessary has not existed. Unfortunately, the one thing that I have discovered in my recent experience with government is a sense of turf protection. I suppose it's natural, but I think when we try to jealously protect our own pieces of turf, we lose sight of the initial objectives of what we are setting out to achieve.

There was a recent visit by members of HCFA, the Office of Investigation, and the Office of Program Integrity to the New Jersey fraud control unit. They summarized their visit and what they found. I would just like to read to you a paragraph of that report.

"With very few exceptions, virtually all the nursing home cases received by the fraud control unit had been referrals from the State agency. This degree of cooperation was not arrived at immediately, but took a considerable period of time to establish. In 1975, when the fraud control unit was established, there was a degree of suspicion on the part of the Medicaid agency that took some considerable time to overcome. More recently, however, a marked spirit of cooperation has arisen. This spirit is manifest in the number of referrals and the fact that the investigative unit is able to regularly hold review and training sessions for the Medicaid audit staff to sensitize them to what to look for in performing their audits."

The New Jersey unit is probably a model in the sense of the now developed cooperation and cooperative effort between the State Medicaid agency and the section 17 unit. This existence is not, as I understand it, duplicated in all of the units. For this to be successful, it goes without saying that the State agencies and the section 17 units must join hands, they must meet, they must sit down, they must have dialogue, and they must work out a cooperative effort by which these cases can be identified, directed, investigated, and prosecuted.

How that is achieved is up to each State and each section 17 unit. I don't think that you can map out one universal plan. Each individual agency and State can work out their own plan of cooperation and objectives. I think, personally, it is a good idea, and a very necessary idea, for the prosecutor to be involved in the up-front stage of case identification because he can give the input as to what kinds of cases can be prosecuted, what kinds of cases the resources of his office can handle.

But irrespective of what my opinion is with regard to the individual nuances that are worked out, there must be a joining of hands between these agencies, so that we don't fight each other but we fight the people who we are mandated to ferret out.

We view this as such an important responsibility. We don't intend to look over the shoulders of the section 17 units and insure that they are dotting their "i's" and crossing their "t's". But we want to work cooperatively with them. We simply have the obligation of the certification process and the recertification process. One of the things we have to do is try to work out a common identification of the effect of these units.

Congress is giving all of this money, and they are going to want something in return. Well, we have to come up with a viable way of measuring success. Success, in prosecutive units are not measured by numbers, not how many indictments you have, how many investigations you have, because one single investigation of this nature can take two years to make. But if you are successful you are maybe responsible for ending millions of dollars of rip-offs. Okay -- so we have to jointly show how we can measure the effect of these units, if we can in some way measure deterrents.

If you take the provider who is on the payroll and has ripped off in one year $50,000 and we find out, how do you measure the success of that prosecution in terms of dollars? Well, you have eliminated $50,000 but, is it not fair, for example, to say, that, well we have saved not only the $50,000 that was ripped off, but if it's safe to project that if that provider would have been in the system for another two years, that's another $100,000 that you can project that you have saved the government. And the legitimate amount of money you no longer have to pay, so there's maybe -- let's say for the sake of argument -- another $50,000. I don't know if this is fair or not, but these are the kinds of things that we and the units are going to have to try to show, that there is a justification for them in a dollar and cents way to measure.

Lastly, I think that these conferences are lacking in one respect. All providers are not crooks, and all providers are not thieves. Many providers are interested in ridding the system of those who detract from their profession. And it seems to me that it would do these kinds of conferences well and good to invite, not only as members of the audience but as panel members, the experts from the provider end. Get their input, pick their brains, so that we could improve upon our efforts and maybe some day we will achieve that effort.

MR. HYNES: The story I'll tell you this afternoon could very well have happened in any State that you represent. I think the passage of the section 17 legislation may go a long way to stop that, but it is not a pretty story. The wellbeing of any system is dependent upon the full participation of all its constituents.

Over the last decades, government has increasingly acknowledged this responsibility to provide a program of health care and to equalize the economic extremes that are the source of social injustice.

Hard figures on the cost of quality health care don't exist. And yet, we are continually made aware of the mounting inflation of these costs. The Department of Labor reported, in August 1978, that rising medical costs were a major factor that year in driving up the cost of living for retired couples by seven percent.

For too long, fraud and mismanagement have been hidden within the cost of health care. These costs are not easy to identify as a figure on a scale because obviously buying health care is not the same as buying staples.

For over four years, my office has dealt with the problems of Medicaid fraud and mismanagement. And while we have been reasonably successful in identifying and solving many of these problems, it is clear that lasting improvement will require a major overhaul of the program of delivering and paying for health care in this country.

Let me review, briefly, our experience in New York. What happened to the nursing homes in the early 1970's and what has happened since 1975. In the early 1960's, Louis Kaplan, then New York City's Commissioner of Investigation, conducted an extensive investigation of fraud and abuse in the ownership and operation of the city's nursing homes. He found that many of the operators of these homes were guilty of stealing hundreds of thousands of dollars. And as a result of the investigation, some of the operators agreed to pay back to the City of New York a portion of the funds in question.

However, their names were never publicized and none were prosecuted. Kaplan, in concluding his investigation, reported that, "Beyond the specific instances of fraud and abuse as they may be revealed and must be dealt with, we are bending every effort to produce constructive results that will prevent further occurrence of cheating and misrepresentation -- Results that will strengthen administration of regulatory and medical care programs of City departments and above all results that will upgrade proprietary nursing homes in respect to operational effectiveness and quality of patient care -- all in the public interest."

Reviewing the press clippings, which trumpeted the Kaplan investigation and its results, one can feel confident that never again could such a scandal sap the resources of City government. One could conclude that government had responded, had taken effective means to contain and eliminate fraud from the health program.

And, for a time the fear of exposure did have some effect on the nursing home operators in New York City, including the ones discovered by Kaplan, who, incredibly, were permitted to continue to operate as operators in the health care delivery system. What is more incredible, however, is that while government through Kaplan had exposed the mal-administration of New York City's health program, nowhere was there an attempt to add to the budget of any prosecuting agency in New York City funds necessary to prevent the recurrence of cheating and misrepresentation that Kaplan sincerely believed would be a by-product of his investigation.

And so, the experiences learned by Kaplan, the techniques of discovery developed by his staff, remain buried in the municipal archives, never to be used again.

What should have been learned fundamentally, from the Kaplan investigation, is that the investigation of health care fraud is an extremely complicated matter requiring a constant vigilance. Looking back on what has occurred in New York City in recent times, it is difficult to understand why after the Kaplan investigation, only one of the five district attorneys in New York City maintained a fraud bureau, and that bureau spent practically none of its resources investigating health fraud.

And so, New York City continued to pour hundreds of thousands of dollars into a system designed to care for its elderly, and allocated not five cents for investigations. It was left for the regulators of the Health Department to discover impropriety. And their low staff levels made the predictable results that little was discovered and what was discovered was never referred to a City Prosecutor.

In the 1960's, the Federal government made New York City's blunder seem inconsequential by comparison. The Medicaid and Medicare programs were introduced to give to the elderly and to the poor a means of obtaining decent health care. And while millions were appropriated to fund the program, which included a small portion to fund the regulators, no money was allocated for the prosecuting agencies of this country. One can only assume now that if a question of fraud was considered at all, the architects of the program naively believed that the State and Federal prosecutors could adequately deal with any problem. Of course, Medicaid and Medicare grew over the years to an almost geometric proportion of the State, county, and Federal budgets.

By early 1970, in New York State alone, nearly three billion dollars a year were appropriated to fund the various parts of the program, and still no money was budgeted for prosecutors, many of whom in urban areas throughout the State were already overburdened by street crime. In New York State the possibility for scandal was heightened not only by this fact, but by the serious undermanning of the State Department of Health. By 1970, there were no more than 12 to 14 auditors to examine the books and records of more than 2,000 facilities, which included shared health centers, hospitals, laboratories, individual providers, and nursing homes.

Beginning in 1970 through 1975, each year the New York State Department of Health requested additional auditing staff for the Bureau of the Budget and each year their request was summarily rejected. So, by 1974, the number of facilities within the jurisdiction of the New York State Department of Health reached 2700 and still no additional auditor lines were added.

During the summer of 1974, the New York State's Assembly Committee on Temporary Cost of Living, led by Andrew Stein who is currently the burrough president of Manhattan, had unearthed a number of allegations concerning fraud and poor health care particularly in nursing homes

located in New York City. The revelations of this committee began to appear with regularity in the New York Times under the byline of John L. Hess and the Village Voice with stories by Jack Newfield.

Other New York City reporters, including Steve Bauman, then an investigative reporter with Metromedia News, began to discover more and more instances of what was described as outrageous care, stale food, patients forced to lie in their own excrement with bed sores unattended. And as the stories developed, what was considered particularly outrageous was that this was not something new. Hess and the others in developing their stories discovered the Kaplan investigation and the fact that operators investigated during that period seemed to be the same individuals who were responsible for massive fraud and poor care in 1974.

Investigative reporters in the Western part of New York State, in Buffalo, led by Moe Argenio and Anthony Cardinale, of the Buffalo Evening News, began to write stories about similar experiences in that area of New York State. By the latter part of 1974, we had in New York State what amounted to a media explosion, which had blossomed into a scandal.

The allegations focused principally on the pattern of fraud, poor patient care, and widespread hints of political influence. By November of that year, Hugh L. Carey was elected Governor and, in the wake of the press outcries, he directed his nominee for Secretary of State, Mario M. Cuomo, a highly respected attorney in New York, and currently New York's Lieutenant Governor, to conduct a preliminary investigation, and to make recommendations on how the Governor should proceed.

In late December, Mr. Cuomo reported to the Governor that a public commission ought to be created to conduct public hearings and to recommend legislation to improve conditions within the nursing home industry.

Additionally, he recommended the creation of an independent special prosecuting agency to investigate allegations of criminality statewide. On January 10, 1975, the Governor appointed Morris B. Abram, a highly respected lawyer, and the former President of Brandeis University, as Chairman of the Moreland Act Commission.

And he recommended to the Attorney General, Louis Lefkowitz, that I be appointed a Deputy Attorney General or a special prosecutor. Since that time, with nearly 500 employees in offices located in the large urban centers across New York State, we've grown to be the largest white collar crime investigative agency in the country. There have been 184 individuals indicted, and out of 120 completed cases, 9 have had their cases dismissed, 10 have been acquitted, and 101 defendants have been convicted.

The office has both criminal and civil divisions. The combined efforts of these two divisions have returned to the State over 6 million dollars in cases, and 3 million dollars more in assignment of property for recovery.

As a result of a five-year investigation of the proprietary nursing home industry, we have identified more than 63 million dollars in over-

payments to nursing home operators, having a Medicaid impact of over 40 million dollars.

Now it is important for you to know that our success came from no special magic, from no monopoly that we had on brilliant investigtive techniques. Clearly, the success of our unit in significant measure was the result of the unselfish commitment that we have from the New York State Department of Health. Under the leadership of the then Commissioner, Robert Whalen, all of the resources of the Health Department necessary to sustain the success of my office was given to us. Without any reservation it was the position of Dr. Whalen that there was simply no pride in authorship.

We had to have in New York State, what amounted to a partnership devoted to making nursing homes decent places for our senior citizens.

In August of last year, as a result of a bill passed by Congress, with the full support of Secretary Califano and the Department of Health, Education, and Welfare, and signed into law in October 1977, our jurisdiction was to expand and to include all of Medicaid.

We and other States who applied for the benefits of this bill received 90 percent Federal subsidies for three years. Consistent with the precedence established by Dr. Whalen, New York's State Commissioner of Social Services, Barbara Blum, has given my office unstinting cooperation in our State-wide investigation of ambulatory care.

It is Commissioner Blum's and my hope that this joint effort, will rid forever from the Medicaid system of New York State the parasites who for too long have tried to destroy quality health care.

Today, 23 States have Medicaid fraud control units. To the Medicaid directors in this room whose States have Medicaid fraud control units, I urge you to put aside parochial interests and to work for the success of these units. For their success and your success. Just as their failure will be your failure. If this program doesn't succeed the legacy we will leave to the eighties, and beyond, is economic chaos.

Health care in this country is the second largest item in the Federal budget next to defense. And this nation is on the threshhold of adopting a national health insurance program designed to help, for example, the uninstitutionalized elderly poor, to name one group, designed to alleviate the fears of the 24 million Americans who have no public or private health insurance programs and 88 million more who have no insurance protection against catastrophic medical expense. But unless we prepare and are willing to make the commitment to contain forever the fraud and abuse that invariably affects social welfare programs, make no mistake about it, we face chaos.

I am confident that, as the prosecution statistics are returned across the country over the next several years, and as funds begin to flow in instead of out of government, Secretary Califano and the Congress will feel a great sense of pride for supporting the fraud control program.

While the balancing of funds to protect us comes too many years too late after the funds designated to comfort us, thankfully, it is not too late. As we step closer to a time when we recognize our responsibility to provide maximum health care to our disenfranchised citizens, we will be ready as never before to contain fraud and abuse.

MR. LIPPE: I want you to be assured that, both the Office of Inspector General and HCFA are aware of the need for upgrading the status of, and support for, the SUR and other similar activities in single State agencies, in not permitting an inordinate imbalance between the quality and support given to the fraud control units versus that which is given to the fraud and abuse components of the single State agencies. HCFA will, of course, have the lead role in achieving those goals, but the Inspector General's Office in its general oversight will play a partnership role in aiding that effort.

The Inspector General has new responsibilities for determining which units shall be certified in the first instance, or which units already certified will be recertified. If the unproductivity or the non-productivity of a fraud control unit is no fault of its own but, it is determined that it is principally the result of the failure of an SUR unit, or a similar unit in the State agency to refer what are otherwise good cases over to that unit, that fraud control unit will not be penalized. It will not lose certification; it will not have its staff reduced. If, on the other hand, there simply isn't the caseload, then we'll simply have to address that issue.

It would be ludicrous to penalize a fraud control unit if, in a rare instance -- and I'm pleased to say, that such instances that I'm describing are indeed rare -- it is the single State agency that is creating the problem, it will not result in a penalization in any form or manner of the fraud control unit. I am confident that that will be the policy.

QUESTIONS AND ANSWERS

QUESTION: It seems to me that the assumption is being made that if a section 17 fraud unit is not receiving enough referrals or enough cases to act upon that that becomes the fault of the single State agency. I'd like to suggest that that's wrong, and I think that the real reason that they are not coming up with enough cases is that you've been too restrictive, in that they are limited to Medicaid provider fraud, not even provider abuse, and no involvement on the recipient end. Is the legislation so restrictive that you can't broaden their involvement?

MR. PATTON: The legislation has been reviewed and my recollection of what came out of it was the fact that it was restrictive. The intention of the Congress was that it was intended to take a look at provider fraud and provider fraud only, the idea being that the provider abuse situations did not require the same expertise as far as prosecution is concerned and in fact, would not lead to prosecution. One of the things that section 17 was to bring about was the provider prosecution where there was, in fact, fraud. My recollection is that the legislation is restrictive. It was intended by Congress to give the fraud units the control over only provider fraud.

MR. HYNES: I think the Congress was very sensitive to the concerns that the single State agency not feel it's being driven out of the business of investigational detection. But, in addition, I've recently had a conference with Commissioner Blum from my State. We've agreed in certain abuse cases, that our civil division would handle those cases and go into Federal court under the section which permits a $2,000 per item special fine. We are trying to work very closely on abuse cases, but trying to limit them as well. We don't want to get too much involved in the whole area.

QUESTION: In our case, the situation has been just the opposite. The section 17 unit is somewhat overloaded. Part of it is simply a matter of definition of what constitutes fraud and what constitutes abuse. If we have a question as to which is which, we give it to the section 17 unit and let them make the decision. After all, they are the ones who are going to eventually prosecute the cases, and if they can't prosecute it, they give it back to the single State agency, and we go ahead with the abuse and recollection and possible suspension activities. I would like to point out, however, that Mr. Piazza left out one of the major faults of the program itself that results in abuse, fraud, waste, and everything else. That's simply the utilization of what I refer to unreasonable instead of reasonable cost principles for both long term care and acute hospitals. As long as those continue to exist, there will be both reasonable and unreasonable interpretations of what are includable and there will also be some rather substantial situations where there is less than arms length dealings between the owner of the facility, and shall we say management rental, services, and referral agencies.

MR. HYNES: Let me just briefly address your first point. I think the method that you have established in you State is commendable. Those of us who have been in the criminal prosecution business most of our professional careers have often as much difficulty as you do in determining up from what is the distinction between fraud and abuse. It seems to make eminent sense that you bring the prosecutive agency, in this case, the fraud control units into that difficult cutting process at the very beginning and let them make those determinations. It's the only way the system is going to work.

QUESTION: I called the office this morning and they told me two things about the area of particular interest here. One is that we are going to be reviewed by the IG for this coordination process between the section 17 unit and the single State agency. One day they are going to spend with the section 17 unit and two days they are going to spend with the single State agency.

Second, we've been asked to give a report to them to help them quantify the savings, or cost avoidance that may have accrued as a result of this fraud and abuse effort. Last year, we did quantify, in the State of Michigan, what we've done with the Medicaid Management Information System in administrative remedies in terms of avoiding costs. And I would like to cite a few statistics and point out the fact that there is going to be a disparity here between these data and what we'll be able to quantify on fraud and abuse.

Last year we avoided some $145 million in costs by taking the following actions: $25 million were avoided because we didn't pay duplicate claims or we identified the fact that the client was not eligible, the provider wasn't eligible, or that the service was not a covered benefit. There were another $18 million we didn't pay because there was a third party liability and somebody else should have paid the bill.

There were another $10 million we picked up because of cost settlements in recoveries from people who had used bad practices, not fraudulent loans, in billing us. And there were $93 million we avoided because they tried to charge us too much and we wouldn't pay. When you put it up against fraud and abuse, it sorta makes them pale into insignificance, and it makes it very difficult for us and for you to prove that we are optimally referring as many cases as we should and that we are prosecuting them as fast as we should. It's a tough job.

MR. LOWE: I think that's one of the biggest jobs that we have in terms of the IG's assumption of the overseeing of these units. We have not come up with a systematic quantifiable scale or plans to measure the deterrent effect and translate that into dollars or into tangible means. I think that is one of the first things that the section 17 units have. I think that's one of the first priorities that we are going to have -- to sit down with them and any other people who might have some input to try to see if we can quantifiably measure deterrents. I don't know if it's possible. I'm not sure that it is. I think that there are some methods that can be achieved. But I'm not certain that we can come up with a full scale documented scale to show that these units have had this deterrent effect exemplified by this.

I don't know if it can be done, but I think we are going to try. We'll go the drawing board and see if we can. It's innovative. One area is quantifying how many providers you have removed and calculating the kinds of money that they were ripping off and that they were being paid legiti.. ely, and projecting how long they would have been on the roles, and calculate that. That's just projection but it may be a legitimate basis by which to quantify.

ANSWER: It is our view that we have to be able to identify for the people who are putting out the legislation and putting out the money, that in fact, not only do fraud control units have an impact that can't be -- to use a bad word -- dollarized but that SURS type activities, in fact, accomplish more than simply get back for programs the dollars that come back in overpayments.

We are looking at this activity and trying to come up with a way which we can, in good conscience, use to demonstrate the impact that SURS type activities in fraud control units do have upon the Medicaid and Medicare programs. We are open to suggestions on ways that could be done. We are talking to top people who are supposed to be able to come up with some mathematical ways of projecting these things, but if you have any suggestions or any comments that you feel would be useful for us in this area, we would like to hear them, and we would like to discuss them with you.

ANSWER: The ways in which we will try to develop some barometers for the effectiveness of the total fraud and abuse effort not just that of the fraud control units, is to try to take a collective analysis of all those States, especially in those States in which there is a fraud control unit established, and a collective analysis of all of their operations with input both from the units and from the single State agencies. I think it is fair to try to develop an absolute measuring stick -- so many cases per investigator or so many dollars per unit based on number of prosecutors or number of SUR people is ludicrous.

Because there is the intangible deterrent effect which, certainly from a prosecutor background, is a nightmare to try to quantify. There are ways -- overpayments identified, civil recovery activities -- but it has to be with your input. We don't have the panacea for trying to come up with a universal uniform kind of measuring stick. Anybody who has a good universal measuring stick, speak up, 'cause we haven't yet found it.

QUESTION: On the civil recoveries, how effective have the $2,000 per claim civil penalty provisions been? Have fines been assessed? Is this being used in lieu of, or in conjunction with recovering overpayments?

ANSWER: I honestly can't give you a figure. We've only had the bill for about a year and a half. We have used it. It's been very effective in the nursing home area. You have to make a distinction between the dollar value put on the penalty and your ability to recover that dollar. It's one thing to assess the penalty of $750 thousand which we have recently done in one case, and another to see the fruits of that $750 thousand. But I'd say in the cases where we have used penalty interest damages of $2,000 in false claims the past year and a half, that the dollar figures probably exceed 2 or 3 million.

COST CONTAINMENT

Moderator:
Richard W. Heim, Director
Office of Intergovernmental Affairs, HCFA

Panel Participants:

Beverlee A. Myers, Director
California Dept. of Health Services

The Honorable Joseph C. Czerwinski, Representative
Wisconsin Assembly

Russ Hereford, Project Director
Health Care Cost Containment
National Conference of State Legislatures

MS. MYERS: Thank you very much. Welcome to California.

I think in either my present or previous incarnations, I know at least half of you. I have been around for quite a while, as Dick was saying, and I am pleased to welcome you officially as well as personally to the State of California.

It was just over a year ago that I first discussed with Governor Jerry Brown the prospect of assuming the responsibility I now have. There was, at that time, a conservative, grass roots movement underway in California, which had managed to place on the ballot an initiative measure that would reduce property taxes drastically. The measure was known as Proposition 13. You may have heard about it. A year ago the governor assured me that Prop 13 was not going to pass. He had just been successful in getting through the legislature a bill that provided a more moderate approach to property tax reduction. He was certain that, in this bill, the voters would recognize a suitable response to their protest against high taxes, and they would reject the more radical terms of Proposition 13. As you know, this was not the case. Of course, we really didn't need Proposition 13 to tell us that the cost of Medicaid is a significant political and fiscal issue. It was not long after Medicaid programs first began that we learned of their amazing capacity to absorb taxpayer dollars.

In California, for example, the Medi-Cal budget has grown at an average rate of 18 percent per year over the last decade. Medi-Cal expenditures for the next budget year are projected to go over $4 billion, representing approximately 16 percent of the total State budget. Medi-Cal is the largest single program in California State government. Thus, Medi-Cal, like most other Medicaid programs, is a target of opportunity in an era of fiscal limits simply by virtue of its size.

On the general principle that any government program must have 10 percent or more fat in it, Medi-Cal represents, in the view of the suddenly cost-conscious politicians, an opportunity to cut $400 million out of the State budget -- a tidy sum. Most other Medicaid programs have budgets considerably smaller than California's but the size of those budgets, relative to total State expenditures, remains substantial.

I know that many of you are under the same demands that we are in California to come up with a Medicaid cost containment in the order of ten percent or even more. The dilemma, of course, is how we can do this without jeopardizing the mission and principles of Medicaid. I am convinced that it cannot be done through piecemeal restrictions on eligibility benefits, or fees within the traditional approach to purchasing health care for the poor. Instead, it will require a thorough restructuring, beginning with a rethinking of our fundamental premises and leading to significant modifications in the way we pay for and deliver health care.

Over the next few minutes, I will try to outline for you how we are proposing to do this in the Medi-Cal program. When we tackled the problem of cost containment we found it necessary, first of all, to clarify for

ourselves what we regarded to be the fundamental principles of a Medicaid program.

We developed five premises that constitute the basis on which we are approaching the cost containment issue. They are the following: Premise Number One: Medicaid is, above all else, a health care program. Its objectives, operation and evaluation should all be defined in terms of health care delivery. In most States, Medicaid has been an adjunct to the welfare establishment rather than, in California, a public health establishment program. In many States, the health departments initially avoided the Medi-Cal program.

In Welfare terms, Medicaid is a form of income maintenance. A perspective, which at best, is obfuscated and, at worst, has conflicted with the program's health care objectives. Over the years of Medicaid experience, there has been growing recognition that the program must be, first of all, a health program. This is the most important premise for restructuring Medi-Cal.

Premise Number Two: health care delivery to the poor, under a publicly financed program, has inevitable differences from the privately financed health care of the general public. We have been deluding ourselves with the simplistic interpretation of mainstream medicine for the poor. The concept is a philosophical principle of commendable intent, but it has useful meaning only as a statement related to the intended impact of the Medicaid program. It should not be taken as a prescription for the process by which the program should meet its health care objectives. We now describe the mission of Medi-Cal as bringing the health status of the poor to the same level as the health status of the non-poor. The manner in which this is done we consider a matter of strategy rather than a fundamental premise.

Premise Number Three: the resources available to publicly-funded programs are limited and they are going to become more so. This is so obvious at the present time that it hardly needs a statement, but it is one of the major premises under which we must now operate. As I am sure most of you know well, stringent budget restrictions put a Medicaid program in a double bind. Cost containment requires major program change, but well-managed program change requires significant staff resources, which, in turn, represent additional costs. After we finish this listing of premises, I will suggest to you how we are trying to resolve this dilemma.

Premise Number Four: a Medicaid program should have the freedom to employ all delivery system alternatives, ranging from the traditional fee-for-service mode, through various contracting alternatives, to direct provision of service. This country's health care industry is characterized by variety and change. This is especially the case in California. There are differences in the efficiency and effectiveness of alternative systems for health care delivery with Health Maintenance Organizations presently symbolizing the desirable end of the spectrum. It has always made good management sense for Medicaid to select, from among the available alternatives, those that are best suited to the program's needs, and

under the curtailment of resources this is even more important. This does not mean a global attempt to spawn HMOs is the only alternative, but it does mean we should try to incorporate in Medicaid the principles that seem to make organized health systems, such as HMOs, successful.

Premise Number Five: among the existing modes of health care delivery, the system commonly labeled "fee-for-service" is least desirable for Medicaid. Fee-for-service is a shorthand way of referring to the health care system that dominates the American scene; private entrepreneurs, many operating for profit, reimbursed for each individual service with provider-patient and provider-provider interactions occuring on an ad hoc basis rather than systematically. The deficiencies of this system, as a health care delivery mechanism, have been thoroughly catalogued by its critics and need not be repeated here. Among those deficiencies is the lack of effective cost-control or fraud and abuse control. Yet, the predominant, de facto strategy of most Medicaid programs has been to meet the program's health care objectives by allowing beneficiaries almost unlimited freedom to buy into the fee-for-service system.

It is a major premise of our plan to restructure Medi-Cal that we cannot afford to do this any longer. We recognize that Medicaid programs, including Medi-Cal, will continue to be highly dependent on the fee-for-service system for some time to come. It will take years to build alternative systems with the capacity to handle more of the Medicaid population. But we give the highest possible priority to diminishing our present, almost exclusive dependence on the fee-for-service system.

These statements of premise should not be construed as an attempt to default on the program's obligation to supply the poor with good quality health care. On the contrary, we are saying that objective, defined in the most pragmatic terms, must take precedence over philosophical debates about the principles of publicly funded health care.

For example, to defend the principle of unlimited beneficiary freedom of choice of providers when there are situations in which beneficiaries do not have adequate access to any provider is pointless and only keeps us from addressing the real problem. These five statements of our premises should indicate the direction we are planning to go with Medi-Cal. Simply stated, it is away from the traditional fee-for-service, as I have just described it, and toward the use of organized health delivery systems.

I have already alluded to the HMO as one example of what we mean by the phrase "organized health systems." Perhaps it is natural for us in California to turn to the HMO model because we have here the most extensive experience of established and successful health plans, such as Kaiser and Ross-Loos. To the extent we know anything about health care delivery with certainty, we know that such organizations are able to deliver good, quality care at costs ranging from ten to 40 percent less than that of the traditional fee-for-service system. Within the Medi-Cal program, we estimate that our current contracts with HMOs save at least 15 percent over the fee-for-service system. No other cost-control method that has been used in large-scale health programs has been able to achieve that

impact. I am not saying that a Medicaid program can be operated in exactly the same way, for example, that Kaiser health plans are operated, but I do believe we can translate into Medicaid terms the principles and techniques that seem to make such organized health systems successful. For example, we should be able to develop provider contracts that create the same functional relationships among the single State agency, physicians and hospitals as exists among health plan, its medical groups and its contracting hospitals. I do not regard the HMO model as a panacea. I recognize that there remain legitimate questions about the extent to which HMO cost reductions may be more apparent than real, due to membership selection effects and out-of-plan use.

The Medi-Cal program's experience with prepaid health plan contracts has made it clear that we must always be concerned that financial incentives do not jeopardize quality. Also, it is not altogther clear in operational terms, how HMOs produce savings beyond the obvious effect of sharply reduced hospital utilization. We cannot, however, wait for health services research to resolve the residual uncertainties about the HMO model, faced as we are with the immediate certainties of the deleterious effects of such alternative cost control strategies as reducing benefits or restricting eligibility. We will assume, in California, where nearly 18 percent of California citizens voluntarily receive their health care from such programs, that the organized health care system model is an appropriate one for Medi-Cal. Our ideas for restructuring Medi-Cal are embodied in a set of six concepts which we refer to as the Medi-Cal initiatives.

Initiative One calls for the development of contracts with organized health systems. The most direct way to bring the elements of organized health delivery into the Medi-Cal program is to contract with entities that meet our definition of an organized health system. This was the rationale for the prepaid health plan program in which we have prepaid-capitation contracts with HMOs and HMO-like organizations. We are generalizing the concepts to include organized health systems that do not necessarily fit the formal, Federal HMO model, and to include payment arrangements other than the usual full-risk-capitation method.

The second initiative will involve contracts with county health systems and, where appropriate, the delegation of Medi-Cal administrative responsibilities to counties. In California, the counties are legally the providers of last resort not only for Medi-Cal beneficiaries but for indigents who do not meet Medi-Cal eligibility criteria. The populous counties have health systems covering both outpatient and inpatient services, and a significant portion of the Medi-Cal dollar goes to reimbursement of care delivered through these systems. In the past, the State has treated the county health systems much the same as any other Medi-Cal provider, without recognition that the State and the county share a common social mission. We now view the counties as partners with the State in the task of providing health care for the poor. Indeed, those counties that operate their own health systems can be viewed as the mechanism through which the Medi-Cal program has direct provision of services to its beneficiaries. At a minimum, we intend to contract with county health facilities on a prospective budget or, similarly, all inclusive basis, so

that both the State and the county avoid the cost of the fee-for-service claims processing systems. For some counties, or groups of counties, we may, in fact, delegate significant aspects of Medi-Cal administration.

Under the third initiative we will develop contracts with individual providers. In addition to our contracts with organized health systems and with counties, we intend to develop contracts with the high-volume Medi-Cal providers, including both hospitals, individual practitioners and clinics. These contracts will be characterized by prospective determination of payment levels, all inclusive rates, and some degree of risk assumption by the provider. The objective is to use the contract relationship to make such providers part of an organized health system with other elements of the system provided by the department, either directly or through other contracts. A key element of this initiative is limiting the number of hospitals participating in the program through the mechanism of special, time-limited provider agreements, whether or not the hospital contracts with us on a prospective basis. With the excess bed capacity in California, where the average occupancy rate is less than 60 percent, we are suggesting that we should not, through Medi-Cal, continue to subsidize and encourage this expensive component of the health care industry. As Governor Brown stated, in his State of the State Message, and I quote, "Not every provider has a constitutional right to all the Medi-Cal dollars he might wish to have." We propose to establish criteria for selection of participating hospitals that would include: access, quality, economy, need and other social objectives; reducing the unit cost; and, perhaps, helping to reduce the excess capacity in the State.

Initiative Four calls for the development of volume purchase arrangements. Good management of any large enterprise, including an organized health system, includes taking best advantage of the economies of scale resulting from volume purchase. Under this initiative, the department would use its purchasing power to reduce the cost of inputs -- products and services required by health care professionals. At present there are two major elements of this initiative, volume purchase of pharmaceuticals and contracts with regional laboratories for exclusive provision of non-emergency, out-patient laboratory services.

The fifth initiative calls for improving fee-for-service cost controls. Although our major theme here is to move away from total reliance on the fee-for-service system, we recognize that this will always be a major component of Medi-Cal. In the meantime, we need to continue the development and refinement of cost control measures relevant to fee-for-service. We will attempt, for example, to extend the concept of reasonable cost reimbursement for hospitals to include reasonable limits on allowable costs for each cost category. A secondary objective of this initiative is to increase the relative desirability, in the view of the provider community, of organized system alternatives, vis-a-vis the fee-for-service sector.

The sixth, and final initiative, we have labeled "Improving Medi-Cal Management Methods." This initiative addresses program management functions that cut across the lines of the first five initiatives. For

example, even if we were not changing the nature of the Medi-Cal program, we recognize the need to improve our Management Information System capability. With an anticipated shift away from the fee-for-service claims, and their traditional fiscal intermediary role, it is even more important that we define fundamental data requirements, measures of program need, resources expenditure measures, program evaluation techniques, and so forth. At the same time we are in the process of moving into a new fiscal intermediary contract, and converting from our previous relationship with Blue Cross-Blue Shield to Computer Sciences Corporation.

A key element in improved management is directed toward the beneficiary. Our objective is to assure that beneficiaries will have a well made, meaningful choice. We are proposing that funds would be used to inform our clients of the values of preventive health services and about the choice of organized and unorganized health care systems available to them. In those areas of the State where it appears we have developed systems that permit choice, we would insist that, at the time of eligibility, application or determination, as a condition of eligibility, the client make a choice. This is a model of choice that Federal and State employees, at least in California, are familiar with and, increasingly, unions through private business. We are now beginning to develop the specific plans for carrying these ideas forward. We face two major constraints: authority and resources.

Many of our program modification ideas require new statutory authority at the State level and, in other instances, we desire to have a legislative mandate as a base before we get into the courts. In order to obtain this authority, we prepared a legislative proposal, which was incorporated in a bill recently introduced by the California Senate Health and Welfare Committee, and had its first exposure in public hearing yesterday. As you might imagine, many of our ideas for restructuring the Medi-Cal program have attracted the displeasure of powerful interest groups, and we expect a long and arduous debate on this bill, particularly in California, which has a full-time legislature which never seems to go home. In the last two weeks, the California legislature has introduced over 600-700 bills, some 150 of which affect my department.

In the meantime, we do have authority for many of these initiatives and will be carrying out some of them in some parts of the State as pilot projects, and we will be proceeding on that kind of a basis. The authority issue also relates to Federal law and regulation, but I would point out that we have had very good cooperation from the Regional Offices as well as some assistance from the Central Office and from HEW in terms of commenting and giving us assistance on formulating some of these ideas.

Our strategy is to incorporate as many of our program change ideas as possible into a revision of the State plan. Also, we want the State plan to be structured in such a way that it allows flexibility in the application of methods from one part of the State to another, without violating the principle of Statewideness. When necessary, we will seek Federal waivers, and we are also prepared to propose amendments.

Perhaps the key element preventing more HMOs from enrolling Medicaid

clients is the volatility of the eligible population. The on-again-off-again phenomenon prevents HMOs from adequately predicting utilization patterns. We are seeking Federal legislation which would guarantee FFP to continue for four to six months on behalf of cash-grant recipients who enroll in a qualified HMO or other prepayment program.

The problem of constraints on resources is a more difficult one since, even if we had complete authority now, we would be unable to act upon it quickly. I have been able to obtain commitment from the governor to invest a considerable number of dollars in restructuring the program, but we are still operating under a prohibition against adding more people to the State payroll. Our strategy for dealing with this constraint is to depend heavily on the use of interagency agreements and contracts with other organizations to accomplish many elements of the program restructure. For example, in California, we have a Health Facilities Commission. It has responsibility for collecting and disseminating hospital and long term care facility cost and revenue information. We hope to have technical assistance from the commission in developing contracts with hospitals that will require a budget review and the establishment of rates. We want to use health systems agencies for assistance in the selection of hospitals, for special contracts and, where appropriate, as a source of technical assistance in development of organized systems. We plan to use the University Health Services Research Centers for applied research specific to our program, and we will look to other contracting sources for assistance in the development of Management Information Systems, economic analysis, planning, and so forth.

We recognize that we have set ourselves a very ambitious goal, particularly with the constraints under which we must operate. However, I see no realistic alternative. The usual methods of cutting costs in a Medicaid program exacerbate the already antagonistic relationship between the State and the provider community, reduce beneficiary access to care, and usually turn out not to contain costs at all. As long as we see the problem only in terms of the budget for the next fiscal year, we will never get at the underlying problems of payment methods, and delivery methods that make a Medicaid program virtually unmanageable.

The proper goal of Medicaid cost containment, as I see it, is not to pare a few percentage points off next year's budget; instead, it is to turn Medicaid into a health program capable of fiscal integrity. This is the direction in which we are heading with Medi-Cal in California.

REPRESENTATIVE CZERWINSKI: The nature of my talk is what is going on in the State of Wisconsin relative to health care cost containment. In Wisconsin, we have, as California does, an energetic State legislature, and some time ago we recognized that the economics of health care were a peculiar mode and that the most effective thing -- although not entirely dependable -- we could do was to influence the supply of services, and the nature of those kinds of services to, hopefully bring some constraint to the ever-expanding health care dollar.

The State of Wisconsin was interested very early in passing what is called a "Certificate of Need" law. That is the law now in the State of

Wisconsin, and it seems to be working effectively. We have $3 million of costs directly cut from further expansions of health care facilities, and we have had over $50 million voluntarily withdrawn for consideration for the purposes of constructing hospitals, nursing homes, kidney dialysis treatment centers, ambulatory surgical units, or HMOs.

The interesting aspect of Wisconsin's Certificate of Need law is that it includes physicians' office equipment. In Wisconsin, the Department of Health and Social Services has the ability to disapprove a piece of equipment costing $100,000 or two pieces of equipment which cost $150,000 or more, within a physician's office.

A second unusual aspect of Wisconsin's Cerificate of Need law is what we call "decertification." Because Certificate of Need is reactive to new development, and only new development, we thought it was important to look at existing services and institutions available to the citizens of Wisconsin. So, along with Certificate of Need, we have the ability to decertify the existing services in the following categories: heart catherization, radiation therapy, chemo-dialysis, kidney transplants, high-risk maternal, neonatal, open heart surgery, and a host of other specialized services. We felt at that time and continue to feel that these services exist in plenty and ought not to exist with so much surplus. The standards that we use in decertification are somewhat like the Certificate of Need policy. For instance, in order to begin a new open heart program, it must be evidenced that the existing program is doing 350 open heart operations a year. In order to start a heart catherization lab, it has to be evidenced that the existing heart catherization lab is doing at least 500 catherizations a year. In terms of paranatal or neonatal services, it must be shown that there are at least 15,000 total deliveries in the last five years, and that a certain percentage of those would have to be under a certain weight before a new service could be provided.

The next initiative by the State of Wisconsin was the establishment of our Rate Review Committee. The Rate Review Committee has the ability to approve hospital rates on a prospective basis or concurrent basis. I am delighted to report that the Rate Review Committee is doing halfway well. We now have an average increase in the rates in the State of Wisconsin of 11 percent versus 16 and 17 percent just a few years ago. We also realized that the matter of education can exaggerate the daily rate within hospitals. In fact, the medical education portion of a public hospital rate can sometimes reach $90 a day per patient. So, the State responded by establishing what is called the "Medical Education Review Committee." It is the responsibility of that committee to approve or disapprove all hospital and medical school affiliations. We develop a plan which hopefully determines where those residency programs are, enhances our ability to retain physicians and enables us to have physicians exposed to different rural areas in the State of Wisconsin.

All of these programs are lodged within the Department of Health and Social Services. All of these programs, plus medical assistance, is within the same division. We did that by accident, but I think it has proven to be a valuable alignment of personnel. The Rate Review Committee can easily share information with the data bank of the Medical Assistance

Program. Utilization review is terribly important in the groupings that we establish in our rate-setting mechanisms. I have recently noticed a number of States which are establishing separate divisions for medical assistance. I hope those States think carefully about moving in that direction, because there is a great deal of data, a great deal of information to make the job easier if there are relationships with other cost containment efforts in State government.

I think the future emphasis of cost containment in health care financing is principally in three areas. First of all, there are going to be more hurdles and greater accountability for physicians in making their decisions. We have now established a mechanism whereby physicians in the State of Wisconsin refer patients to nursing homes. In the past, we would have a little slip of paper saying "Does this patient belong to a SNF or an ICF"? And a physician would almost, in a knee-jerk reaction, check off the place where that patient would do best. We now have a pre-arranged meeting while the person is still in the hospital (where most of our patients come from). Patients usually move from hospital to nursing home. We have a predischarge meeting with the family, if any exists, county social worker, the physician and a social worker from the hospital to determine the most appropriate referral. That has meant, and will hopefully mean in the future, more intelligent referral of patients to adequate services in the community, including home health care, personal services, chore services, "Meals-on-Wheels", et cetera.

Second, the State of Wisconsin is interested in expanding what it is now equipped for in terms of cost containment data information, to become heavily involved in providing assurance on a more broadly based system, that those near-poor and those with heavy medical bills, will have another system prior to and, hopefully, without going into the Title XIX area. The State of Wisconsin is proposing that we do four things: first, establish minimum standards for all health insurance disability coverage sold in the State. In other words, Art Linkletter cannot have a Sunday editorial suggesting that you take diphtheria insurance.

Second, the State is now involved, and has gotten through one house of the legislature, a catastrophic insurance bill, based upon a person's medical bills and the amount of equity that person may have.

Third, we have a bill which would provide a conversion for those people who lose their jobs, are involved in a divorce, or what-have-you, and find themselves without the comfort of group insurance for a certain period of time. The bill is completely supported financially -- not politically -- by the insurance industry, and we are hopeful that that bill will be passed in the very near future.

And, finally, in financial partnership with private insurance companies we have established a risk-sharing pool for uninsurables. Those people who have been turned down by the private sector twice will have the ability to subscribe to the risk-sharing pool which the State of Wisconsin and the insurance industry contribute to.

We are looking at greater participation by the patients. What we try to do is survey the health care delivery system and find those places where the patient does have some latitude and does have the ability to make some decisions. In that, we have introduced a bill that will have a $6 co-payment for emergency services. Any person who goes to an emergency room must pay the first $6. We are looking at other places within the system where the patient is the consumer. I would love to put a co-payment feature in for physicians but that opportunity is not here yet.

Finally, and probably in the long run, the most significant activity going on in the State government is the issue of physician supply. We have three ventures now in consideration. First, we are limiting the size of enrollments at both of our medical schools. Second, we have a tuition grant program, and the pay-back of that tuition grant program is based upon that student's decision on what kind of physician he or she will be, and, also where that physician decides to practice. If that person, for instance, becomes a family practitioner and practices in rural areas in the State of Wisconsin, there will be 100 percent disallowance of the pay-back. If, however, that person becomes a neurosurgeon in Chicago the full force of the loan will be felt.

Third, as long as we put some responsibility on the medical students, we decided to put some responsibilities on the medical schools. Their funding will be affected by the school's success in the development of primary care physicians and places where those physicians decide to practice. We are hopeful with this conglomeration of efforts that the State of Wisconsin will be able to address some of the increases felt by all other States.

We are also looking, rather sheepishly, though supportively, at the national cost containment bill, which I support. I think I can accurately say that the Department of Health and Social Services also supports it, and that puts all of us in a whole new situation since it will probably include Medicare as a State administered and monitored program.

All those things combined will hopefully make for an exciting future, and a plausible means to approach the challenge of rising health care costs.

MR. HEREFORD: I think Joe Czerwinski just gave a very good overview of what one State legislature is doing in the area of health care cost containment. I think the Wisconsin legislature is probably doing more than most in that area. There seem to be some legislatures that have done a lot and others that really don't seem to have done too much in that area.

Coming to Washington, D. C. from New York and getting involved a little bit more in Federal policy and Federal politics than those at the State level, it is always interesting to see how we often have to remind Federal officials that there really are States out there and once you get outside of the Capital beltway, there is a whole other land that exists. And we often find, working from the State legislative perspective, that a little push has to be given. You can't just go to the executive branch

agencies but you also need to deal with the State legislatures. I think State legislatures are becoming a much more powerful force and are becoming much more heard, both in the State capital and at the Federal level.

What I want to do here very briefly is touch on three separate points. First of all, why State legislatures are concerned with health care cost containment. Everybody knows they like to do good and like to help everybody, so why should they worry about controlling costs?

Second, I want to touch just briefly on a few of the initiatives that States have undertaken recently to attempt to control health care costs. And third, I want to describe the role of the National Conference of State Legislatures and explain a little about where health care cost containment fits in with one of our priorities at the Federal level and through our efforts with the States.

Appearing here before a group of Medicaid directors, it is easy to think of cost containment in terms only as they apply to the State budget and the Medicaid sector. That is the area that you need to focus on because that is where most of our State expenditures go. Legislators really need to take a much broader view than just that. I guess there are several reasons. One of them is that they have to pass a State budget of which Medicaid is a very large portion. They also have to deal with other than just Medicaid costs, though, because they are a major employer. I am not quite sure how many thousands and thousands of employees the State of New York has, and by the time you start adding up the health insurance policies and the benefits which those employees receive, it adds up to quite a tidy sum.

Second, legislators are trying to improve the economic environment of the State and make businesses more competitive. If businesses are faced with a problem of trying to remain competitive, when the cost of their health care insurance benefit packages for their employees keeps rising faster than their profits can rise, it is just like the State budget which creeps up a little bit more each year. It is the same thing in any business. At the same time, employees feel the pinch. They no longer can get a real increase in the standard of living and in disposable income because an increasing proportion of that income, or of their benefits is eaten up from year to year by health insurance. I think it is very significant that about a year ago when the coal miners were on strike, the major issue involved health insurance and health benefits. Taxpayers face growing frustration, and I think everybody knows what taxpayers mean to legislators. They see more and more of their dollars just going to pay for health care costs under Medicaid, under Medicare, and State health plans for county indegent payments.

And, last, States would like to establish more programs such as the catastrophic program that Representative Czerwinski described, such as New York, Minnesota, Rhode Island, and, I believe, Hawaii have enacted. They like to provide these things and provide as wide a range of benefits as possible to the population, but the problem is that the costs are out of control. They can no longer afford it. It is the very problem that the Carter Administration is facing at the Federal level on the issue of

whether you enact a comprehensive national health insurance program or whether you deal with it piece by piece and see how your fiscal resources and fiscal capabilities are, as each section comes up. State legislatures have taken a variety of responses to attempt to deal with this. I think the most visible one and the one people most talk about are hospital cost containment programs. Currently, I guess, 17 State legislatures have enacted some type of cost containment program. They range from the one currently underway in California, which is basically a submission of data with a little more to a State agency, although there are attempts to expand that, to one that is in place in Arizona. Under this system any hospital that comes to the program or wants to increase its rates, must file a request with the State health services department and with the local health systems agency, which reviews it. If the State feels that the rate change requested is too high, it goes on a publicity campaign to try to get the hospital to hold its rate of increase down somewhat. To some extent they have been successful in that approach. The ones most often cited are in nine States which have either mandatory or quasi-mandatory cost containment programs that cover all payors. I think it is very important that they cover all payors.

From my staff days in New York and the creation of the cost containment program there initially applied only to Medicaid and Blue Cross, and as the State cut back on reimbursement to those two payors, we saw kind of a balloon or pillow effect. You squeezed down on Medicaid or Blue Cross and, at the other end, the charges to private pay patients went out of line. In some cases they were twice as high for similar services in some of the cities if you were a private paying patient than if you were a Blue Cross patient.

As a group, the rate of increase from these mandatory programs is about 15 to 20 percent below the national rate of increase. The States with the mandatory or quasi-mandatory programs, in 1977, experienced a rate of increase in hospital cost of 12 percent versus a national average of 14.2 percent, and versus an average of 15.8 percent in those States that have no such programs. In '78, preliminary data shows that the rate of increase is under ten percent versus almost 13 percent on a nationwide average.

The hospital industry has been talking a lot about the voluntary effort as one means of controlling health care cost, but if you look at the experience of the voluntary effort, I think it is fairly clear that the programs in these mandatory States bring down the rate of increase nationally to the level which the industries claimed. I think it is important that these cover some type of prospective reimbursement system which puts hospitals at least somewhat at risk. One of the beauties of dealing with State legislatures and States is that you soon come to realize that every State is a little bit different, and each State is the one that best knows the needs of its people and the needs of its facilities. It is probably at the State level that we should focus such programs for cost containment efforts.

This year, West Virginia has enacted somewhat of a cost containment program which requires the filing of financial reports with the State

health department as well as publication of a summary of the annual report in a local newspaper. And it authorizes the State department to manipulate the data and to analyze the data to see in which areas constraints are needed.

The Florida legislature went into session on Tuesday. Staff people think there is a very good chance there may be some kind of a rate-setting commission bill enacted in that legislature this year. Obviously, it is a little too early to tell, and things can happen between now and the governor's signature, as you all know, but I think there is very good opportunity in that State. Several other States are also looking at cost containment legislation for hospitals.

A few other areas are important besides hospital cost containment. I think it is very significant that the concept of Certificate of Need in health planning really began at the State level some ten years before it was picked up in Federal legislation. It was first enacted in New York in 1964, and picked up by another half dozen or so States by the late '60s.

An interesting piece of legislation this year is in the Utah legislature. It has enacted a "Pro-Competitive Certificate of Need Law," which is kind of inconsistent in its own terms, since Certificate of Need is really the ultimate regulation of health facilities. But this would encourage, in the Certificate of Need determination process, a look at what market forces could be brought to bear, and how a project would impact on market competition. It is an effort to bring HMOs and things like that into line, or into more reality so they can be more widely used, and encourage other efforts along this line.

A New York program was recently enacted to establish what is called, "The Nursing Home Without Walls Program," to begin to look at long term care. I am sure, as State Medicaid people, you are well aware that that is the largest chunk of the Medicaid budget. It is growing all the time. The New York program is an effort to reduce this perverse incentive where we said, "If you put your elderly relative in a nursing home, the government is going to pick up all the costs for you. You don't have to pay anything. But if you keep him at home and provide some of the care yourself, you are going to get stuck with a good portion of the bill." This is an effort to turn those incentives around so Medicaid will reimburse for a full range of nursing home level services to people in their own homes. It is also an effort to cut down on the bricks-and-mortar approach to health care. Nowadays, I think, if you look at the cost of constructing a nursing home, you find that about 20 percent goes solely for depreciation. It seems a lot more logical, a lot more humane to pay a full hundred percent, or at least as close as you can get to that in the way of delivery of services, rather than putting a fifth of your budget solely into capital construction.

A few other examples -- the State of Michigan enacted a law last year to encourage closure and conversion of excess hospital beds. Joe Czerwinski mentioned the Wisconsin program on decertification of health services. These are a lot of the steps that State legislatures, with the cooperation of State agencies, in most cases, are taking to help control health care costs.

Finally, I just wanted to touch on the role of the Conference of State Legislatures. It is a national organization that represents the 7,500 State legislators across the country. It has three main purposes. One is to improve the performance of legislators and legislatures.

A second is to foster interstate communication and cooperation. I know from my legislative staff days, it is always interesting to find out what another State is doing in a certain area. It certainly can provide some more insight into what should be done in your State, what is possible, what is politically reputable -- a very important focus.

And the third one is to give us decisionmaking voice in Federal policy that comes out of Washington, which all too often -- at least it seems from our perspective -- ignores the States and, to some extent, the State legislatures.

Cost containment is a major priority there. I don't think there is any question about it. As an organization, we have been in the forefront in supporting the President's cost containment bill, with a couple of minor modifications that have gotten a very sympathetic hearing on the Hill. We have worked hard to push for the enactment of this legislation. Significantly, it permits State programs to continue to operate. There should be some funding available to assist in the developmental costs of new State programs.

And, finally, under this grant that we have received from the Health Care Financing Administration on cost containment efforts, there are three or four major purposes and three or four tasks that we are performing. One is to serve as a funnel both from HEW out to the States on what the Feds are doing, and from the States back to HEW on what some of the States are doing.

A second one is to encourage this State-to-State communication -- again, let one State look at another and know what is going on there. We will also be putting out a monthly publication. The first one appeared about two weeks ago, describing activities on last year's cost containment legislation. The next one will be coming out within the next week, describing this year's cost containment legislation at the Federal level, and the impact that will have on some of the State programs.

We will also be sponsoring a national conference on State and Federal cost containment initiatives to be held in Washington on May 31st through June 2nd. After that we'll hold a series of regional meetings to follow up on the priorities that State legislators and some of the members of the executive branch, who could attend, have been able to identify.

I am reachable in Washington, at NCSL's office. If anybody wants further information on the grant or what some of the States are doing, I would be happy to answer any questions for you.

CONFERENCE LUNCHEON

Leonard D. Schaeffer, Administrator

Health Care Financing Administration

MR. SCHAEFFER: Just about four years ago this time, I marched into Bob Fulton's office. He was then Administrator of SRS, and I told him in no uncertain terms about my complaints on behalf of the State of Illinois regarding the arbitrary and capricious decisions of the Federal government. I now occupy Bob Fulton's office, and every day I look at that door fully expecting to see the Illinois delegation come marching through repeating that speech to me. In order to forestall that, I decided to join you at this meeting.

I think this is an excellent opportunity for you to discuss some of the issues that you're facing in the Medicaid program. The original concept for this speech was to remain fairly narrowly focused on the Medicaid program. However, I've had a lot of questions about many issues that are not necessarily Medicaid specific. So I will try to cover a number of areas.

I've brought copies of the Administrator's Report that describes our reorganization. This document was sent to all of the Medicaid Directors and to all of the Directors of the umbrella agencies on March 29 when it was announced. I remember Illinois, though -- things sent to the single State agency sometimes took three to four months to be distributed, so you may want to get them here.

We share a common goal as joint administrators of the Medicaid Program: To promote the timely and cost effective delivery of appropriate high-quality health care services to eligible individuals.

It's an easy thing to state, but probably one of the most difficult tasks in America today. We are trying to do this in a complex and rapidly changing society. I perceive a lack of consensus in America regarding what government's responsibility is to the poor, aged, and disabled. In various States, the scope of the Medicaid program varies significantly due to different attitudes about providing health care to the poor.

Traditional market forces do not operate in the health care industry, thus things don't work the way they work in the rest of our economy. As a result, when we try to do some good things, we often cause some bigger problems. For instance, the reimbursement policies in Medicare and in parts of Medicaid are often inflationary since they are cost-based.

Our tasks are further complicated by the lack of a truly articulated and well connected delivery system. We all talk about the health care delivery system in America, but there isn't one. There is a gigantic cottage industry: 7,400 hospitals, 14,000 nursing homes, almost 400,000 physicians, and hundreds and thousands of other professionals, all of whom are trying to maximize or optimize their own situation.

Very frequently, from where I sit, I see that an attempt to optimize a local situation suboptimizes the national situation. For example, most hospitals are dedicated to their continued viability, or in some cases to their expansion, either in physical plant or types of services. Much of this is counter to what we want to do on a national basis. We

don't want more beds, except in selected areas. We don't want more equipment except when we know we can use it cost-effectively. Thus, the lack of an articulated delivery system makes it very difficult for us to be sure that all of our funding is being used most effectively.

There is also a lack of public faith in big government. The American public has lost its faith in big government's ability to get the job done, in big government as a responsible locus for trying to help people. There are a number of reasons for this. It has to do with some unrealistic expectations that came out of the sixties, as well as some real failures we've had since then.

The existence of fraud and abuse also undercuts public confidence, and allows people to feel justified in criticizing and withdrawing support for our program. To the degree that we tolerate poor program management and don't stop or reduce whatever fraud may exist, our programs are at risk. When our programs are at risk, people who need help will be hurt.

Lastly, I think we are in an era of limits: limited resources, limited dollars, and limited patience on the part of the American public. They want better results. They've seen Proposition 13, and a lot of people seem to like it. Thus, I feel a sense of urgency to improve our program.

If all the problems facing us in trying to get a better Medicaid program together weren't enough, we've got a bigger problem: inflation. I don't know about your State capitals, but in Washington that is THE number one issue. It is the number one political issue, the number one economic issue, and it's becoming the number one budget issue. I think that each of us has felt it. Those of us on fixed salaries have a very good sense of what inflation means. It is a frightening phenomenon.

As you know, the President has articulated a program that's aimed at reducing the rate of inflation in this country. It has three parts: a voluntary guideline for business and industry to reduce their cost increases, reductions in government spending, and the reduction or elimination of burdensome regulations.

The issue of voluntary reductions in costs, and reduction in government spending, is central to our program. Health care inflation drives the CPI -- particularly hospital cost inflation. At current rates, which over the last five years have been somewhere between thirteen and twenty percent, hospital costs double every five years. This year, Medicare and Medicaid together will spend 26 billion dollars on hospital services. Assuming current rates continue, in ten years that would be 100 billion dollars just for hospitals! HCFA is the third largest agency in the Federal government in terms of budget. If hospital cost inflation continues, we will soon be the first.

I don't think the country can afford such dramatic cost increases, and I don't think most Americans want them. So one of the efforts that HEW has undertaken is hospital cost containment legislation.

Basically, the legislation places a cap on the rate of increase in total hospital expenditures. It's an econometric calculation, but basically it says that year-to-year hospital costs shall not increase by more than a fixed percentage. Those hospitals that achieve that rate or less will not be subject to mandatory controls.

If a given hospital fails to achieve the prescribed rate, but a whole State achieves the rate, mandatory controls will not be applied within the State. Some States -- particularly those with rate setting commissions -- have come in at less than the proposed cap already. If the country as a whole is below the cap, then there will not be mandatory controls at all.

So hospital cost containment legislation is not an attempt to regulate hospitals. It is not an attempt to get into the financial management of every single hospital in this country. It is an attempt to encourage hospitals to reduce their rate of increase. If, in the aggregate this rate is achieved, individual hospitals will not be subject to controls.

Most importantly, the legislation does much more than simply reduce Federal outlays. It has about a 1.5 billion dollar impact on Federal expenditures in FY80. But it has a total 3.7 billion dollar impact on the economy at large. In other words, the President's hospital cost containment program reduces Federal government expenditures by a billion and a half, and it reduces total costs of hospital care to individuals and to private and to third-party insurance companies even more.

It's my personal opinion, that if health care continues to increase in cost, it will indeed be beyond the means of most Americans, and certainly beyond the means of State and Federal government to purchase the kind of quality care that we are committed to. Thus, hospital cost containment legislation is critical if we're to reduce the cost of health care to affordable levels.

When I talked to the gathering at Albuquerque on the MMIS systems, I mentioned a number of management improvements that HEW is interested in, and that HCFA will be pursuing over the next couple of years and longer.

I would like to talk about some of the steps we've taken, and some of the things that we will be doing in the future.

Our reorganization has involved more than simply a change in the table of organization. I've spent time over the last three months meeting with senior management in the Health Care Financing Administration, with the Public Health Service, with some of you, with Blue Cross and Blue Shield, and with a variety of constituencies that deal with us to learn about the changes we should make in the operation of our programs. To understand the challenges and the opportunities that face us, we had to have those discussions. As a result, we had to redefine our own mission and state our priorities and goals.

In simplified language, this is what we see as our mission. First, we must promote the delivery of high quality and appropriate health

care services to eligible individuals on a timely basis. I think we all share that in terms of each of our programs.

Beyond that, in order to do a good job in what is an increasingly complicated society, I think we have a special responsibility to our beneficiaries. We've got to make sure that both Medicare and Medicaid beneficiaries understand what they are entitled to under both programs. We've got to make sure that our beneficiaries have access to quality care.

Finally, we must make sure that the things we do result in a cost effective delivery system. That's a major change of mission for some of the people in the Medicare program. Traditionally, serving beneficiaries has meant paying the bills on time. Just paying bills is no longer enough. We in the Federal government, and you in the States have to be concerned about cost, or those services will soon be beyond our means. We all must be more sensitive to our impact on the total health care delivery system. By virtue of our size, by virtue of our purchasing power, we impact the entire system. By virtue of our regulations, we leverage that system, and hopefully leverage it in a positive way.

It's my personal feeling, though, that over time our body of regulations has led to some inadvertent incentives and disincentives. Particularly in Medicare, but also in Medicaid, we have addressed each narrow issue as it has come up.

Our problem is that solutions to these narrow issues sometimes create problems for the overall system. This is an inadvertent and not a purposeful result. So one of the things we've done is to establish an Office of Health Regulations within HCFA, which is charged with the responsibility for reviewing ALL existing regulations on health care, in HCFA, the Public Health Service, and the Department of Agriculture. That office will attempt for the first time to categorize all existing regulations, and then to review them against two criteria:

1. Benefit/Cost: is adherence to the regulation of benefit to the country at large, or is it more of a burden than the benefit would justify?

2. Incentives and disincentives: I don't think it was purposeful, but in the Medicare program, for instance, the way we reimburse provides a bias toward inpatient care. I think that is making Medicare more costly than it should be.

In addition, we must make sure that the impact we have on the total system is one that promotes new and better methodologies, permits innovation, and allows people to do a better job of providing health care services, not one that's restrictive. We've got to be worried about quality, about cost, and about innovation. You'll see us being a little more aggressive in those areas.

You can look at HCFA another way though, in addition to the mission, you can view us in terms of functions.

We do three things: first, we develop policy and instructions. It's supposed to be clear policy, and we are supposed to disseminate it to all those entities in the health care delivery system that need to understand what we're about. And as our size grows in terms of our purchasing power, more and more people are interested and need to know what we are doing. I hope we will do a better job of communicating. That's really the major thing we do in Washington -- write regulations, intermediary letters, manual issuances.

Second, we execute agreements with contractors and States that define the conditions for both administering and operating the program. We do not, with the exception of the Office of Direct Reimbursement, have direct relations with either providers or beneficiaries. Almost everything goes through States, carriers, or intermediaries. Even our quality control efforts go through either States or PSROs. So, we are once removed from the action. That creates a special management burden and special opportunities. We must set standards of performance for all of our fiscal agents so that they can accomplish our mission.

Further, we ought to be able to benefit by the creativity, the ingenuity, and the special opportunities that occur on the local level. We have to do a better job, in my opinion, of articulating and communicating our expectations, and making sure that the dollars we spend will result in quality health care. But we execute contracts, we don't run the program.

Lastly, we monitor compliance and performance in the administration and operation of our program.

Everything else we do relates to these three functions, or trying to make these functions better. This is the guts of the operation. We are not in competition with claims processors, we are not in competition with fiscal agents, we do not think that we operate the Medicaid program on a day-to-day basis.

It's important, though, that you have a sense of what our priorities are for the coming year. I'll go through these quickly.

First, we have to improve our management control systems, both for HCFA and for our contractors. We have to have a better idea of what's going on in the field, and we have to have a better sense that the whole system is working appropriately. We have a long way to go on that.

Second, a more generic goal is to make sure that we have appropriate utilization and quality of services. That's both the PSRO program and a variety of efforts we have underway in almost all of our programs.

Third, reduce fraud, abuse and waste. It is critical if we are going to rebuild public trust, that we demonstrate success in this area. It is probably the second biggest symbolic issue in Washington behind inflation.

Fourth, we must simplify our programs through administrative integration, thus increasing access for our beneficiaries. In my discussions with

States, fiscal agents, insurance companies, and providers, it's clear that it's extremely difficult to do business with the Federal government, particularly for a provider. Life is made pretty miserable when for the same or similar service, there is one reimbursement channel through Medicaid, another through Medicare, and often a third with private insurance companies.

I think we can do a much better job working as partners -- States, fiscal agents, insurance companies -- to simplify that administrative process. This can be accomplished through changes in the administration of the program, not an attempt to make Medicare look like Medicaid or vice versa. They are different programs, with different social purposes, and a different although overlapping beneficiary group. But in terms of administrative improvements, in terms of the use of advanced technology, we can do a lot to reduce costs and make it easier for people to relate to our programs, and therefore increase the number of providers in the programs, and increase access and services to beneficiaries.

Fifth, controlling reimbursement is a critical problem. Conceptually, it is probably one of the most difficult in all of the Federal, State, and local governments.

I think we can eliminate the current physical separation, the current intellectual separation, and the current lack of urgency in terms of simplification and integration, by both co-locating and integrating.

One important point for you is that there are no changes in regional organizations at this time. Regions do different things than the Central Office.

In terms of reorganization, it is pretty simple. We are consolidating our policy functions from Medicare and Medicaid, and from what was called the Office of Reimbursement Practices into one program policy bureau.

We are consolidating our operations functions for Medicare and Medicaid. These are the people that devise and determine the standards for contractual relationships: for Medicaid, the State plan, and for Medicare, the actual contracts. They will be consolidated into one bureau, called Program Operations.

We will consolidate our quality control functions now in the Office of Program Integrity and the Medicare and Medicaid Bureaus within a new bureau called Quality Control.

Lastly, we will consolidate our support services functions.

The Health Standards and Quality Bureau remains unchanged. As a result, we end up with five program bureaus: Policy, Operations, Quality Control, HSQB, and Support Services. These are all Bureaus, and these are all line functions. We also reduced the number of staff offices to four. We did, though, make one critical change in staff array. We have created an Office of Intergovernmental Affairs in the Office of the

Administrator. One of the problems that we have had, I think, is our inability to talk to States with a single voice in terms of all of our programs. Further, we've had problems regarding crossover claims and a variety of other Medicare/Medicaid kinds of issues, where we've been unable to communicate adequately to States, because the Medicaid program was the single source of that communication.

We will now have an Office of Intergovernmental Affairs. It will report directly to me, and it will be our spokesman vis-a-vis States and localities, and it can represent States and localities in all of our five areas. We will have someone that can represent not only you but your entire State government, and very often, as you know, there are differences of opinion within and among States.

The Office of Intergovernmental Affairs will provide a focal point within HCFA for States and localities to communicate with us. It will not simply be a Washington office; there will be people in the field, both traveling and permanently. Part of its mission will be to make sure that State and local views are aired on all of HCFA's issues and all of our functions.

It will attempt, as a service, to identify the best practices within States, without trying to run any programs. One of the things that I found most interesting in my discussions with many of you is that you're much more likely to take advice and guidance from a sister State than from the Federal government. This office should facilitate that kind of interaction.

It will also arrange for something we haven't done very well, which is to train our people about State programs. One of the things that surprised me when I first came to Washington was the relative lack of former State employees and people experienced in State programs, working in the Federal government. I think we have to do a better job of learning about you and working with you. We would like to arrange personnel exchanges between HCFA and the States. The IPA mechanism has not been used to its fullest extent. I would like to stimulate the use of IPAs and other kinds of exchanges of personnel to make sure that people, both from the States and the Federal government, are put in meaningful jobs and actually contribute to the development of the program and to the State and Federal partnership.

One thing that I didn't mention has to do with performance standards. We are trying to move away from process requirements into performance standards for all of our programs. In doing that, it's evident that people who are Washington based are very good at designing performance standards, but have great difficulty in doing what I call reality testing. Can we legitimately expect States or fiscal agents, contractors, intermediaries, to live up to our standards? That is a very tricky subjective kind of judgment to make. I think we need someone with a little freedom to both talk and listen to help us with that.

Everything I've discussed today has to do with what we want to do and what we intend to do as soon as we finish our move to Baltimore. There

are currently about 400 people left in Washington who will move to Baltimore. The entire move will be completed in June.

We are now appointing the acting Bureau Heads and Staff Directors and setting up transition teams to refine the organization and the staffing levels down to the Division and Section level. The organization will be effective with the completion of our move in June.

Reorganization is not an end in itself. It is intended to provide the structure through which we can realize our mission. It's intended to make it easier for us to address all of those priorities I listed for you. It will allow us to make and disseminate more consistent policy, and it will allow us to simplify forms and to reduce reporting burden. It will allow us to simplify our own administration internally, and through the new Office of Intergovernmental Affairs it should both improve communications and access to States.

However, even in the best array and, with the best possible people, HCFA cannot solve all the problems we face. Medicaid, for instance, is run by the States, and the best we can do is to try to facilitate your activities, try to produce a clear and consistent policy, try to be aware of your needs and problems through the Office of Intergovernmental Affairs, monitor and try to discover those problems where we can provide technical assistance and try to make -- and this is a longer term goal -- Federal matching arrangements performance oriented. We would like to see matching formulas as incorporated in our CHAP proposals, for instance, which give States more Federal money as your programmatic success increases.

We would also like to be involved in publicizing your successes. I've testified before many committees the last couple of months, and discussed in some detail things that have been done in Michigan, achievements in Florida, Georgia, New Jersey and New York.

But our assistance, practically speaking, is just that -- it's assistance. You run the programs. You've got to take the initiative; we've got to help, but you've got to improve management of those programs. Administrative costs obviously are something we're all concerned about. Program cost, though, I don't think we've really looked at as long or as hard as we should. One of our major interests in the coming years will be what can we do to control program costs.

On the Federal level, we know surprisingly little about the Medicaid Program. We are unable to provide the most basic formation. You run the program, but Congress holds <u>us</u> accountable for both monitoring it and describing to them how things are going. One of our initiatives in the next few years will be to improve the way in which we gather and use program data.

By better management, you can also improve public perceptions of the program. As I said earlier, I think public perception is probably more harsh and more negative than the reality of how we are running those programs. But that perception is translated into what State legislators

and Congressmen do, and I think to the extent you manage well, you can demonstrate success, and that can be turned into support. I also think that improved management will improve provider participation, and that's critical in terms of providing services to our beneficiaries.

I think we need a joint effort at all levels. Our role has to be more than simply paying for services, and more than just simple oversight. We have to work with you to find solutions, both to the systemic problems and to individual problems in each of your States. We've got to invite you to communicate with us. I hope the Office of Intergovernmental Affairs will help improve communication.

But we have a responsibility to Congress, to our beneficiaries, and to the general public to assure them that the program is going well. We can't tolerate some of the things that I've become aware of over the last several months. We can't tolerate the fact that many Medicaid children are not receiving the screening and treatment services for which they are eligible. We can't tolerate continued reports of fraud, abuse and waste where there seems to be no effort or no result in decreasing whatever the current level may be.

We can't tolerate, and we can't get away with the lack of adequate program data when facing the Congress. Two Congressional Committees have asked me for data about services and error rates that we just plain can't provide. They're angry - I think justifiably so.

We will not try to tell you how to operate your programs, but I think we've got to become much more involved in communicating our expectations, in working out joint performance standards, and then holding all of ourselves accountable for achieving those goals. First and foremost will be the requirement for receiving more accurate and more timely data from each of the States.

We are going to try to develop a data system that will allow us to gather minimum information from you -- we've got to have that data. And we're going to try to move, in both the EPSDT penalty regulation and in CHAP, to more performance-oriented standards than what we've had in the past.

Examples of our attempts to move from process oriented standards to an outcome orientation, to get away from procedure and into performance are: EPSDT and CHAP, QC, and MMIS. In all of these areas you've been given a chance to participate, and by and large you or your representatives have made an impact. We've got to increase that kind of activity, and then we've got to be serious about results, because time is running out for some of our programs.

We're also going to try a first at the Federal level. We're going to try to cooperate with PHS. There are 37 separate Federal child health programs: Maternal and Child Health, Community Health Centers, Migrant Health Programs, Urban Health Programs, Rural Health Programs, you know them all.

We have an initiative underway within HEW which will attempt to unify our efforts across all child health programs. Both the Surgeon General and I are committed to making that work. There isn't enough money to support those programs, and there certainly isn't enough money to support all the confusion and waste that occurs when we don't use those public health service programs as EPSDT sites.

Improving the management of this program, though, requires a clear and consistent set of program instructions so you know what's expected from you. I think the EPSDT penalty regulation will be a good example of how we can do that. Earlier this year, that regulation was pulled back in order to begin a series of discussions with States to make it a more workable document, to make it more outcome oriented, to eliminate process requirements wherever possible. The regulation reflects that work.

As we receive more information about EPSDT and get a better handle on what's really going on, I think we can refine the regulation further. We will continue to work with you, particularly in the area of defining a declination of services.

We think we've developed a fair and clearly stated regulation. It's up to you to implement the program, to reach the performance goals that are set both in the statute and the regulations. We'll help, but I think that at this point we have tried to show good faith, and I hope that you can live with and contribute to the EPSDT program.

In Quality Control, I think there's a similar story, although it predates me. The old QC System didn't work. The sample was too small, the data was too old, and only eligibility errors were measured for a part of the Medicaid population. The new system reflects those ideas and those concerns which you have. The samples increased to 78,000 cases. The total Medicaid population is covered, eligibility, TPL and level of errors are covered. We pilot tested it in the Fall of 1977.

Right now, we're in trouble. The information on July through September, when all States are supposed to have completed their reviews, is just not there. There are only eight States that are on schedule in terms of the QC data. Thirty-nine States are between half and two-thirds done, and three States are below fifty percent in terms of gathering that data. I told Congress we would have this information on a timely basis. When I testified, we didn't have it, but I said we would have this information in the future because we had a new and better QC System developed with State help.

We now are faced with a major failure. There are tables available that show where every State is in terms of collecting this data. We will begin an intensified effort to assist you in getting this work done. We are required by Congress to report. We need the State-by-State data for the Congress. Failure to get it leaves us with only one tool: we'll have to go out and do our own audits. We have the HEW Audit Agency lined up to do twelve States, and we are going to do another twelve ourselves, if necessary.

Using an audit means that a sample is taken, extended, extrapolated, and then a disallowance is taken. I would much rather get information through the QC System. However, I have a commitment to the House Appropriations Committee to get that data. That QC data is a management tool to help all of us to run the Medicaid program.

I think MMIS is probably the most hopeful and fruitful area for improving our relations with you in the sense of moving from process to outcome orientation. We've had very good participation by States on a technical panel, and we're looking forward to seeing the MMIS system become a much more flexible tool. We would like to certify modules. We would like to give ninety percent Federal funding to develop innovative and creative software. I'd like to see us look at actual program impact, and not at process, so that even States that didn't come under the original MMIS program can get some funding assistance from us.

After you help us develop the performance standards, we will begin a process of recertifying all existing MMIS systems. If systems don't meet the performance standards, they'll revert to the fifty percent match; if they do, they'll get the seventy-five percent match.

Further, we'd like funding on a sliding scale, so that in those States where the performance standards are exceeded, we can go beyond the seventy-five percent match. We have some examples right now of States that have done an outstanding job of focusing on particular problems. At superior levels of performance, the Federal government should provide an incentive of Federal funding above the seventy-five percent level.

I hope you're aware of all of these things and you find them to be positive steps. In order to do all we want to do, we need your help, and we need a commitment from you to manage the program, take responsibility for it, be creative, and work with us as individuals and as a group.

There are a variety of things we have to commit to you: we have to listen, we have to be willing to make changes, we have to move from a process orientation to performance orientation, we have to support you when you need our help, and we have to hold you accountable for performance. We have to join with you to make sure the system is an accountable one.

I'd like to make HCFA easier for you to deal with. I would like us all to be recognized as successful managers of programs that help people. I think that through management improvements, we can solve most of our operational problems, particularly the State and Federal problems.

Better management, though, means working together better. To the degree we can do that, we'll be successful. To the degree we're successful, the poor, aged, and disabled -- who depend on us -- will benefit. If we fail, I don't think anybody here will get hurt, but our beneficiaries will. We must be successful.

Thank you.

LEGISLATIVE PERSPECTIVE

PANEL

Karen Nelson, Professional Staff Member
Subcommittee on Health and Environment
House Interstate and Foreign Commerce Committee

Ann Sablosky, Legislative Assistant to the
Medicaid Director

MS. NELSON: This is a particularly hard time, I think, for anybody to tell you what is likely to come out of the Congress in the way of legislation affecting the Medicaid program. In one sense, it is probably the most clouded picture we've had in the Congress in a long time regarding big policy issues, if you will. On the other hand, it is also the clearest picture in terms of a whole number of relatively small kinds of policy amendments that will have a great deal of meaning to many of you. These two different tendencies in the Congress, one, to look at some big policy issues in an as yet quite undefined way, and this other track of looking at very specific things, are going along right next to each other. And at the moment, it's hard, both for us and the Congress, and for you out there, I'm sure, to tell where indeed it will all end.

One of the reasons the picture in the House is particularly difficult to read right now is that there have been significant changes in both the membership of the committee that deals with the Medicaid program, and in the chairman of that committee. I guess it was sort of a new experience for all of you, about four years ago, when Medicaid moved over to the Interstate and Foreign Commerce Committee's jurisdiction. It meant that now a health committee was looking at the Medicaid program as opposed to the traditional taxing and welfare committees. Indeed I think we are still going through a process where members of that committee are learning about the program and deciding what approach they want to take to it. In this last Congress, however, the chairman of that committee, Paul Rogers, announced his retirement. This year we have a new chairman, Henry Waxman of California, and about eight new members of the committee many of whom have not served on the health committee before, and will come to the Medicaid program with really a fresh outlook. So that's one thing that makes it hard for us to tell what they'll be interested in pursuing.

The second thing that makes it difficult when you look at the Congress this year, is this overriding concern that you've heard a whole number of times already -- not wanting to spend any more money. The pressures this year are probably more extreme than I have seen in any year in terms of this great desire, on the part of the Congress, to respond to what they perceive as a public demand, if not to balance the budget, at least to cut down those deficits. The President, as you know, already came in with a small deficit in his budget. The budget committees are tripping all over themselves to come up with a smaller deficit than he has projected. When I left the office yesterday, it still looked really nip and tuck as to whether the budget committees were going to approve any kind of new funding initiatives for programs like CHAP or better coverage for the disabled. All of those programs may end up being a situation where, with such an overall budget resolution for the Congress, the Budget Committee is going to say our policy is not to allow any new starts for these sorts of things. That doesn't mean that the door is completely shut on these programs, but it means it will be an extremely difficult task for the legislative committees to get them out on the floor and get a positive vote on them. So that's a strange situation.

The third difficulty in reading the Congress is one that's a little defused, but one that's fascinating to watch -- particularly on the Senate side -- is an emerging divergence of views on what you might call the

major issue, national health insurance and how Medicaid might relate to that. Senator Long has become very vocal pushing his catastrophic health insurance plan. I'm sure, as many of you know, he has been introducing a piece of legislation for a number of years, the Long-Ribicoff plan, which has a catastrophic component and Federalized Medicaid component.

This year, he introduced that bill again, but he also introduced a bill that was catastrophic only. Half of Washington is trying to read the signs as to whether he is really serious about pushing that bill. It certainly looks like he is. And he is on a course of trying to bring that bill out to the Senate floor, and pushing it over to the House side. That has brought about an equal and opposite reaction from Senator Kennedy, who has long been an advocate of a comprehensive national health insurance program. He is expected both to fight that bill, and also to push legislation which will take a whole different approach for providing health care for the poor. So he is pushing a national health insurance plan, which has not yet been seen in final form, but the outlines are floating all over Washington, where Medicaid would become a program where States buy their AFDC population into private insurance coverage on an experience-tested basis. And what would otherwise be left to States, other than paying that premium bill would be some sort of a residual Medicaid -- those small number of medical benefits that weren't included in the basic private health insurance plan -- and a long term care program. That's obviously, a big switch in how you go about providing health care to poor people. The major chairmen in the House are as yet uncommitted. Waxman, of our committee and Rangel, of the Ways and Means Committee have not yet given a definite indication of where they are going to come out on this.

Jim Mongan was here earlier in the week telling you some about the Administration's health insurance plan. They do fall somewhere between these two extremes, but again, that's another plan we haven't seen the details of. Interestingly enough, in one of the early versions of their proposals, they were talking about a health care plan for the low income. Their proposal is to have a Federally-run health care plan for the non-Medicaid poor, and to have that run at least for the initial three, four, or five years of the program simultaneously and on a separate track from the Medicaid program for the poor people who are otherwise included in Medicaid; a rather unusual administrative structure, but that I guess they think it's the best way to phase that in. That's not a definite part of their plan, but when they went around and talked to all of the congressmen about what they were thinking, that's the kind of idea that they put forth, as a way that they might phase into better health care for the poor.

So you can see, there are a lot of different ideas floating around out there, and they are all being aggressively discussed in Washington right now. The time will come, very shortly, when they are going to be discussed in the form of actual legislation. Who is going to win all of these fights? Believe me, it is just as hard for us to tell as it is for you. But that is kind of background as to what the situation is like. There is a lot more specific legislation which is moving along with at least some reasonable degree of predictability.

You heard from Len Schaeffer about the major initiative of the Administration. That's the hospital cost containment bill. I think that bill and the CHAP bill will probably occupy most of our committee time for the first nine months or so of this year. Cost containment is the first bill that we're looking at. It's important because the big initiative this year is to try to save some money and provide money to do other things with the health care program. I don't really need to go into the details of that bill with you; I just might make three or four comments about it.

One is that it is a bill that's going to be extremely difficult to get through despite the push by the President, and despite the emphasis that has been put on it by the leadership in the Congress. It is a bill which is hotly opposed by the various interest groups. The hospitals don't like it; the physicians don't like it; and, indeed, the lobbying campaign is already in deadly earnest on the Hill.

I would just say that, so far, I haven't seen any indications from State Medicaid directors that this legislation could be a good thing for us. Maybe you don't think it could be, but I suspect it's the kind of thing that might be useful to all of you because it does give you a way to hold down your program expenditures, and I think it is worthwhile letting people in Washington know of your interest and concern with that bill.

Much of the debate in Washington will probably focus on whether the appropriate role for legislation is to only look at Medicare and Medicaid and say, we'll change the way those programs pay for hospital care and we'll try to institute what we think are the appropriate savings in those programs. We'll let the rest of the health insurance payors take care of themselves, and let the hospital industry react in whatever way they think is appropriate when they've got controls only on those two payors or whether the appropriate role is to go across the board and set a policy that's going to influence everybody who pays for hospital care. The Administration has proposed an approach that will set an overall limit on expenditures so that hospitals cannot shift costs from one payor to the other, and cannot turn down Medicaid patients because they don't feel that they pay as well as other patients. On the other hand, for a long time in the Senate, particularly, the Talmadge bill has been actively pushed, and it would put the changes into the Medicare and Medicaid programs and hope that the other payors would follow voluntarily on their own. One of the big decisions, I think, will be which way to go in that kind of fight, both on the Senate side and the House side. The other relevant point in regard to that legislation is that, partly as a result of the consideration last year and the interest of the Congress, and partly as a result of interest expressed by the States, the current bill proposed by the Administration and, also the Talmadge bill are quite open to alternate State cost containment systems. Where you do have States with organized cost containment efforts, like Maryland, Massachusetts, New York, Washington, Connecticut, et cetera, they would be able to operate in place of the Federal program as long as they had some reasonable degree of effectiveness. The big difference between the situation now and what the situation would be under that bill is that if those State programs were recognized, and if they were governing the cost containment effort, Medicare would

follow the rules of those State programs just as Medicaid does, just as the other payors do. Many of you may know that right now there is really only one State program that has any control over the way Medicare pays for hospital care, and that's Maryland. In Maryland, for example, they make Medicare pay some of the bad debt share of hospital costs and they feel that they have developed some equity among payors which has helped them to make that system more acceptable.

Another big piece of legislation is CHAP. I should ask you to tell me about that because you had a session on the Administration bill yesterday and we are still waiting to hear what the bill will be, so you know more than I do on the score. Let me just say this: our committee last year did pass a CHAP bill. We never did get it to the floor of the House. I would say, generally, if you could find one piece of legislation that has a great deal of support in the committee, and I think in the whole House, the CHAP legislation is it. It was really as a result of deliberations in that committee last year that the concept of covering all kids up to some kind of a minimum income level nationwide was introduced. That's now in the Administration bill. The committee was very interested in assuring that there was an adequate increase in the Federal matching so that States, in effect, would not be asked to bear a great financial burden because of the change in this program. That will continue to be in the House bill, I think. We are somewhat concerned that it may not be in the bill that the Administration sends up -- at least not in amounts that we think are adequate. We will wait to hear.

The other thing we are interested in is what we think will be in the Administration bill -- again, I'm not sure if it's in the latest version -- regarding some greater standards for appropriate reimbursement for providers who are willing to participate in CHAP and say that they will be comprehensive care providers. One of the concerns a lot of members had last time is that they might be putting a great deal of additional money into this program, and yet, in the end, not assuring that additional people got services because they weren't going to overcome one of the very severe problems in the program; that is, insufficient provider participation. So we are most interested to see what the Administration has to suggest on that score.

There are maybe ten other pieces of legislation -- some of them in the Talmadge bill, some of them that passed the House committee last year -- that I think we can say with about 99 percent degree of certainty are going to become part of the law this year. I'll just do a quick run-through of them. Most of them are probably quite familiar to you because they've been kicking around for so long.

One is to put some provision in the law which will override the freedom of choice provision, at least for laboratory services so that States can start to contract on a competitive basis, if they wish, with providers of laboratory services. I expect, there will be discussions as to whether there are other services where it is appropriate to extend the override since the patient exercises very little choice. And that's one thing we'll be looking at.

Another one is to improve Medicaid coverage for the severely disabled. We hear a lot about the problems of people who are in the program as disabled, and if they go back to work and earn just enough money to put them over the substantial gainful employment test, they are no longer considered disabled. And then they fall off of Medicaid. Even where the States have wanted to keep them on, they can't because they don't fit the definition, et cetera. You are all, I'm sure, painfully familiar with that. I do think we'll have some legislation to respond to that this year.

The Administration has proposed legislation which would give a flat three-year extension of Medicaid coverage for these disabled persons. I suspect what's likely to come out of the Congress is not that, but something which will change the definition of the disabled on a more permanent basis for Medicaid coverage, and probably override, for purposes of the definition of disability, the substantial gainful employment test. You'd still have your income limits in Medicaid in terms of whether people are covered, but in trying to decide whether they're disabled once on the roles, that test, I suspect, will disappear.

Two other things that were in the legislation last year; one is the requirement for common audits between Medicare and Medicaid for all cost payors, and I think that's already in the Talmadge bill. It did pass the House last year. It is only a matter of time until that becomes law.

Another provision allows hospitals to swing beds back and forth between long term care uses and acute hospital care. That's again another virtual certainty. Among other provisions that have popped up over and over, is protection against loss of benefits when Social Security checks go up by the cost of living amounts. We sort of have that in the law now but there are some people who were left out, people in nursing homes and other places and we will put through those technical corrections, to take care of that.

Last year, we tried to give the States the option to provide Medicaid coverage to hard to place children who, once adopted, often lost their Medicaid eligibility, and because of that, they weren't adopted, and it becomes kind of a vicious cycle. If we do pass that, I think it will be totally at State option, but would allow you to cover those kids if it will assist in the adoption procedure.

We are going to increase the matching rate and the ceiling for Puerto Rico, Guam and the Virgin Islands. We had that almost to the floor of the Senate last year, and then lost. I think we will make minor changes in the requirement for HMOs participating in Medicaid to give the HMO three years from the time that they are certified by the Federal government to meet the requirement of serving no more than 50 percent Medicare and Medicaid. That's been a problem a few places, I think, particularly in California.

I think we will probably see a provision enacted this year which will allow you to determine someone ineligible for Medicaid if you have evidence that they disposed of resources in order to gain coverage.

In addition, we have a few more that we are thinking about that I know are of some concern to you. I think this one is particularly a problem with Nevada, and maybe a number of other States. It will allow you to take people off the Medicaid roles if you already know they are no longer eligible for SSI, but it is just taking awhile for the system to catch up. That's one that we are interested in doing.

We are beginning to think about a program to help pay, particularly the hospital cost, for undocumented persons. That is the new way we refer to illegal aliens. I don't know that that has such a direct effect on your Medicaid program; it certainly has a direct effect on a lot of State and county costs. One of the things I'd be interested in hearing from you is how this should be done. There are various proposals about how it should be done, through Medicaid as a new category of eligibility for limited benefits or some sort of a separate program, providing funds directly, either to counties or to hospitals. I tend toward the second, but I'd be interested in knowing what you think about that. It is a big problem for places like Los Angeles and New York City, and others.

I expect we will come up with some kind of legislation to try to respond to what the House committee has been very concerned about, a lot of unnecessary surgery that goes on in both Medicare and Medicaid. Exactly how that will come out, I don't know, but it will probably be a strengthening of the kind of requirements that are put on PSROs in terms of what they need to do and what sort of review they should do.

I don't want you here to fall out of your chairs, but there is discussion as to whether we should take another look at the old provision in Medicaid law that says you don't have to cover all SSI persons, but can maintain some more restrictive standards, if you wish to do so.

There is obviously a trend -- slow but real -- toward more standardization in the Medicaid program, and obviously that old 209-B option stands out as a sore thumb. Again, I would be interested in hearing from a lot of you who have taken that option as to how severe a problem you think that would be. When we originally put that in the law, we thought there was going to be a great explosion of people on the Medicaid roles as a result of SSI. I was interested in looking at the study that was done in the Social Security Bulletin which tells you that that's true one place and not true another. It's kind of hard to estimate, but on the whole I think we've had enough time to know the scope of the problem. I think, particularly, if we deal with some of the concerns you've had relating to things like disability, and disposal of resources, at least it might be time to think about whether that's a worthwhile policy to pursue.

Beyond that, of course, there are some relatively large pieces of legislation which the Administration keeps hinting they are about to send up to us that we haven't seen, and I think we will get some discussion on this year, but I don't know if we can anticipate much action. One thing is that they are proposing to change the way Medicare pays physicians and probably move to something like Statewide fee schedules with less differentiation among specialties and less differentiation among urban and rural areas. Their proposal is listed in the budget. They don't indicate

that they intend to extend that to the Medicaid program, but if they don't, we do. I think from Len Schaeffer's remarks this morning, it's only a logical thing that they would -- if they come up with a reasonable way to pay physicians under Medicare -- extend that in some way to the Medicaid program.

The second major initiative they've been talking about for some time is to start setting Federal standards for Medicaid reimbursement in HMOs, and perhaps to require States to contract with any HMO willing to serve the Medicaid population, if they are a qualified HMO and if they'll accept the Federally-determined rate. Again, that's only in the initial stages, but it will get some attention this year.

The last thing, of course, is national health insurance. What can we tell you about that? There is this whole array of various and sundry kinds of alternative programs. With the possible exception of catastrophic health insurance, none of them are probably going to go into effect before 1983. The changes are just too big. And, first of all, the Congressional process is going to take a considerable amount of time. Second, I think everybody is aware, as they approach this, that they want enough time to let the administration of the thing get arranged in some sensible way. So I think it is probably not until fiscal year 1983 that we're looking at any changes there. The possible exception is catastrophic which could come in a good deal earlier.

MS. SABLOSKY: I thought I would use my time talking about some specifics on major pieces of legislation that the Senate is considering. Karen has talked some about the Talmadge-Dole bill, and I thought I would just mention several other provisions that she didn't cover in her presentation. The Senate Finance Committee has already held hearings and begun mark-up on their Medicare-Medicaid Reimbursement Reform Act introduced this year by Senators Talmadge and Dole. There are essentially three parts to this legislation: modification of reimbursement for hospitals under Medicare and Medicaid; modification of physician reimbursement in several ways, and modification of long term care reimbursement and certification. There is a companion bill to the Medicare-Medicaid Reimbursement Reform Act, called "Miscellaneous and Technical Amendments." I will describe the several pieces of it that are different. And finally, there are a number of staff proposals which have also been considered in conjunction with the two other bills.

In the area of hospital reimbursement, one of the major provisions is to establish a system which would classify hospitals according to size, type and location, and use that classification system to set up a target rate for paying for routine hospital operating expenses. When committee mark-up was held, there was heated debate between Senate staff and one or two of the Senators about whether this particular provision should be considered in the context of just Talmadge or Dole or whether it really should be given an airing in terms of the broader Administration hospital cost containment provisions. The outcome was that this particular

provision was deferred until a broader hearing could be held on cost containment. And that's where you could really see some of the tension between the two approaches, the approach of just reimbursing for Medicare and Medicaid and the broader Administration approach.

A related provision for hospitals is the inclusion of payments for the closing and conversion of underutilized facilities. This provision was acted upon and tentatively approved by the committee.

In the area of physician reimbursement, there is a provision to provide incentives to physicians to participate in Medicare: by expediting claims payment; by simplifying claims forms; and, by establishing alternative methods of assignment.

There is also a provision to reimburse hospital-associated physicians on a fee-for-service basis for patient care they directly perform or personally supervise. The bill also authorizes HEW to approve use of relative value schedules by physicians in billing under Medicare and Medicaid.

The long term care provisions in the bill include removing the 100 visit limitation for home health benefits under Parts A and B of Medicare and repeal the three day hospital requirement under Medicare. HEW is opposed to that provision for budgetary reasons.

There is also a study for HEW to look at the need for and desirability of requiring dual participation for skilled nursing facilities under Medicare and Medicaid. HEW's position is that a study is not needed and that there should just be a requirement for dual participation. The Administration is submitting legislation to that effect.

The Talmadge-Dole bill also deals with the transfer of asset question, as Karen already mentioned, and competitive bidding for lab services.

As I said, most of the provisions in the Miscellaneous and Technical Amendments are similar to those in the Reimbursement Reform Act, but there are several that are different; one is a two year extension for 90 percent funding to be made available to the State Medicaid Fraud Control Units. Another provision is authorization for the Secretary to conduct demonstration projects for the training and employment of AFDC recipients as home health aides. This provision would authorize the Secretary to designate projects in up to 12 States. And I should note that this was, in part, based on the experience of New Mexico when Dick Heim was the Director of the Human Resources Agency and conducted such a project.

Among the staff alternatives for cost savings, there is a provision to limit reimbursement for outpatient care based on the notion that hospitals are shifting much of their costs to the outpatient departments and Medicaid and Medicare are picking up the payment where they shouldn't be.

There is also a provision to delete the statutory requirement for reasonable cost-related reimbursement for SNFs and ICFs; another provision which isn't too popular with HEW or with nursing homes.

As far as the catastrophic bills go, there are several others that are being considered by the Senate. Very recently, Senator Long introduced a third catastrophic bill. The first bill, the Long-Ribicoff bill, is similar to the one that has been kicking around since 1973. Senator Long introduced a second bill which does not include a Federalization of Medicaid provision based on the notion that it would be easier to get a catastrophic only bill through than catastrophic and Federalization. He introduced a third bill on March 26th, which would require employers to provide catastrophic coverage. Under the first catastrophic bill that he introduced with Senator Long, employers have the option of providing catastrophic coverage, and there is a Federal plan for everyone. In this third bill, there is no Federal plan; employers must provide such coverage, although there are some provisions for small employers and the self-employed to get tax credits of up to 50 percent for the cost of the premiums. Small employers are defined as employers with payrolls of less than $25,000.

Senators Dole, Domenici, and Danforth have also introduced their catastrophic bill. Senator Dole pulled from his co-sponsorship of the Long-Ribicoff bill to introduce his own on March 26th. The Republican version of catastrophic insurance builds entirely on the private marketplace. There are three major parts: it improves Medicare by expanding the present Medicare benefit package in the following ways: it removes the hospital limit on days covered, it deletes the 100 day home health visit limit, it repeals the three day prior hospitalization requirement, and it provides a limited drug benefit. Under the Medicaid improvements in the Dole-Domenici bill, there is a provision for catastrophic coverage for Medicare beneficiaries which is triggered when a person has $5,000 of medical care and 60 days of hospitalization. The second part of the Dole-Domenici bill is a private catastrophic insurance provision which requires employers to provide catastrophic coverage to their employees. Employees don't have to accept the coverage, it's optional, but the employers must provide it. If an employer is not providing such coverages, the employee has a civil right of action he can resort to. And if the employer is not offering an appropriate and approved plan, he will be subject to a civil penalty. In the Dole-Domenici approach, there is also a residual market plan where HEW will contract with private carriers to make available catastrophic insurance for those not otherwise covered. This part also requires States to provide catastrophic coverage for their Medicaid beneficiaries with the same trigger of 60 days and $5,000. States can buy into private insurance plans for these benefits and premiums for the benefits would then be financed through general revenues.

Finally, there are several other bills which have been introduced that I would like to discuss. Last week Senator Schweiker introduced what I'll call an MMIS bill. He described it, in introducing it, as a bill to amend Titles XVIII and XIX to strengthen the capabilities of States in the Federal government to detect Medicaid fraud and abuse.

The bill is based on the notion that MMIS has tremendous cost saving potential which it hasn't even begun to realize since half of the States do not now have MMIS programs.

What Schweiker intends to do about it, through this legislation, is establish penalties for States that fail to institute, and have approved by HEW, an MMIS. Penalties would be in the form of reduced Federal matching funds for the administration of the State Medicaid program. There would be a waiver, however, which would allow the Secretary to waive the requirement for a State to install an MMIS, if the Secretary could justify to Congress that such a State doesn't need MMIS.

There are several other provisions in that bill. In order for MMIS to be approved by HEW, certain requirements must be met according to the legislation. One is that the system must include provider, physician and patient profiles sufficient to provide charting of drug and service overuse.

It also provides that the State must agree to turn over all information on fraud and abuse to State Medicaid fraud control units. And it requires that information on the status of providers be exchanged between the Medicare and Medicaid programs.

I don't really know too much about what's going to happen with this bill. It has just been introduced. Senator Schweiker is not on the Senate Finance Committee. He introduced the bill and referred it to that committee.

The Clinical Labs Bill which was introduced and passed by the Senate, both in the 94th and 95th Congress, was reintroduced this year by Senator Javits. The key provisions of this bill are to expand the existing licensure program to cover large labs as well as intrastate labs, to establish national standards for licensure and to administer this new licensure program through the current Medicare certification system. The bill being considered by the Senate Human Resources Committee does not have specific Medicaid provisions in it. However, it does have important implications for Medicaid reimbursement for labs.

It does include Medicare and goes with the current Medicare policy which allows physicians to bill for outside lab tests. As you know, current Medicaid policy does not allow physicians to do outside billing.

HEW opposes this provision and HCFA is moving in the direction of the Medicaid polciy on this issue, and is considering some of the following alternatives: to require XVIII to conform to Title XIX on the billing provisions; to negotiate fee schedules with labs and drop co-insurance and deductibles, and to include lab discount prices and information used to develop prevailing charges.

The last area of initiatives I want to cover are the HEW initiatives, and some of these are also comparable to legislation that has already been introduced in the House and the Senate.

HEW also has its own transfer of assets prohibition which it has included in the social welfare improvements package which is currently being drafted. It would amend both Social Security and Medicaid to deny eligibility to SSI recipients who have transferred assets of $3,000 or more at less than fair market value.

There is also a civil money penalty provision being drafted at present which would give the Secretary authority to assess a civil penalty against people who defraud the Medicare and Medicaid program. This provision would facilitate action against defrauders in instances where criminal prosecution isn't practical.

Another provision is Social Security wage information and Medicaid eligibility proposal which would permit the Secretary to release Social Security wage information to States determining Medicaid eligibility and permit the State unemployment compensation agencies to release wage information to State Medicaid agencies.

QUESTIONS

DR. HAYES: In these days of cost savings, has anybody gotten around to the idea of thinking about the able, adult child's responsibility to the aged parent, particularly in long term care situations?

MS. NELSON: Well, we've thought about it. I can't tell you that we've determined any legislative policy on it. I think one of the concerns generally as the Congress has looked at it, is to find a way to assure that this doesn't result in sort of a stepback to the situation where the kind of care that's given to somebody in a nursing home becomes dependent on some extra support coming out of the family over and above what the program can give.

That's an idea that has been around for awhile; there is some thought on that, but I can't tell you for sure whether anything is going to happen on it.

DR. HAYES: As it stands now, my mother has Social Security. She is in a nursing home. She pays all of that first except $25, and that, I, as a Medicaid Director, pay the balance. Now, if I've got a sister or brother who is making $100,000 a year, I think that sister or brother should contribute additional funds, in addition to the patient's income thereby reducing the Medicaid portion. That's what I'm talking about.

MS. NELSON: You wouldn't make it a part of the eligibility test?

DR. HAYES: No.

MS. NELSON: You'd be eligible on the basis of your own income?

DR. HAYES: No, I would not use that in eligibility, but I would use it in payment.

MS. NELSON: Give me an idea what you think would be the appropriate

income standard to apply to that relative. I mean, the $100,000 one is easy, I guess. What about $20,000?

DR. HAYES: You can't just simply say a dollar amount. You've got to take into account the family make-up of the adult child, and what is a reasonable amount that is necessary for the wellbeing of that family. Now, I'm no economist, so you're going to have to bail me out.

MS. NELSON: Yes, it's tough. I mean, that idea has a bit of appeal, and in fact there is a lot of good argument for doing that, but there are also some tough arguments on the other side, when you try to get down to what sort of an income standard you should be looking at, how you make a judgment about the need of that family for those funds. I think probably nobody is suggesting that you apply a standard quite as strict as you are applying in the welfare standard itself down to, you know, just a few thousand dollars.

Also, I sort of suspect an awful lot of people who end up in nursing homes have children in their late 50s to early 60s themselves -- so they are not all that far away from when they are thinking about what's going to happen to them when they turn 65, and all of those factors make it difficult to make appropriate judgments.

Maybe what you would really like would be a whole lot of flexibility for each State, about how they applied that, but you have a valid point. I don't disagree with it. In fact, from the viewpoint of overall social policy, it is felt by a number of people that we encourage the standoffish attitude on the part of the child toward their parent by totally closing them out of the picture, and that's of concern as well. Relative responsibility is a rough one.

MS. MYERS: I wanted to talk a little bit about HMOs and whether or not there was any thought given to what we perceive in California as one of the key problems, keeping Medicaid clients out of HMOs. That's the eligibility volatility issue, and whether or not you'd extend it for four months.

We've been discussing this. What do you think the reception in Congress on either side of the Capitol might be?

MS. NELSON: That's one of those that's a little hard to predict for both sides. There are certain issues that are kind of like red flag issues right now in terms of a different view between at least the Senate Finance Committee and the House Commerce Committee, and CHAP is one of them. Many of you may have heard that. And HMOs are another.

Speaking for the House side, I think they'd be very receptive to it. I would not say that, on the Senate side, they would necessarily oppose that particular part of it. As you know, much of the concern on the Senate side has centered on both programs, but particularly on Medicare and concerns about the Trust Fund being taken for a ride, so to speak, by some HMOs. But that particular thing of extended eligibility is one that I think they would be receptive to. Now, the question would be whether

you require a State to do that or whether you allow them to. If it is an allowing kind of thing, then, you know, opposition disappears probably on both sides. I really don't think there would be much problem with that. Is four months enough, do you think?

MS. MYERS: We'd like a year.

MS. NELSON: The Administration did send up an HMO proposal last year that did get introduced, but was not pursued any further, in which they were quite active about setting appropriate rates for payment for people in HMOs.

One of the things that always concerned us about it -- and would probably be of some concern to you as well -- was the fact that they didn't anticipate any cost savings from that bill for quite a period of time. In fact, they anticipated higher costs because they felt that many States who already had people enrolled in HMOs would end up being required to pay a higher rate than they were paying under their current program. It is something that concerned us a little because we weren't sure if you were going to get all that different or better services than you were buying at whatever rate you'd negotiated now. We were a little worried about that. But I would just alert you to that. Many of you do have experiences with HMOs out there, and I think that is a piece of legislation you want to watch carefully, and in fact where your experiences can be most helpful to us in making some judgments about it.

QUESTION: One of the comments made about pending legislation related to the mandatory release of information from Social Security for Medicaid programs. I had the distinct impression in listening to Mr. Schaeffer that there was some general impetus towards cooperation and coordination within HEW. Isn't it possible to get that kind of cooperation without a Congressional mandate?

MS. NELSON: It relates to Social Security benefit information. And Social Security information is protected under a very strong privacy provision right now, and that's what they do need, to get the law changed so they can overcome that. That's where the rub comes in, with the Social Security information.

State Medicaid Directors' Council Report

Glenn Johnson
Chairman

MR. JOHNSON: As a result of our full day's meeting on Monday and another session last evening, we considered some two dozen subjects, and out of it, I would say we have probably around a dozen or so highlights that we would like to share with you today.

Regarding the State-Federal partnership in communications, we feel there is a need to continue strengthening this relationship, and most likely, we will need to redefine the council's organization and interaction or liaison with the new HCFA organization.

On communications, we still stress the point again of hoping that there will be greater acceptance of our meaningful input. We don't mean that you should do everything that we say you ought to do, but I think there is a feeling in a lot of the States that we have made inroads, but we think there is greater room for accommodation or adjustment in administrative processes.

The second item is our continued concern on the rapid integration of Medicaid and Medicare. We recognize it is desirable from the Federal point of view, that you do in fact merge or wipe out the identity of Medicare and Medicaid centrally. However, I think HEW recognized that on a regional level, out in the field, there are two distinct programs and therefore, you just can't join them; you can't merge them. And so our concern is that there is a continued recognition and need to have these two separate programs and how to administer them. We feel State administration inherently requires certain kinds of reaction Federally.

Some did express a feeling of disregard maybe of some of the input we have on the Title XVIII and XIX integration projects. The message is we just don't have the feeling that the input is being translated into meaningful action.

We do object to merging these processes through regulation rewriting. There has been evidence or indications by some of the State people that when we see a new regulation come, supposedly a rewrite, suddenly we find it's a one-track again for Medicare-Medicaid processes.

There was an objection raised under the same heading of two proposed legislative items that would in effect grant the HEW Secretary authority to merge some Title XVIII and XIX operations. Again, we feel there has got to be recognition of the program differences.

There was another subject discussed at length, labeled "Creeping Federalism." We don't want to dwell on it. The States do feel, though, that there is a relentless set of steps occurring, and it appears that the two programs are being jammed together. There were five principles that essentially arose out of the Southern Association of Medicaid Administrators, and I will read them to you: (1) "consultation with representatives of State and local government preceding the development of Medicaid regulations; (2) State variations should be allowed in implementing the regulations, recognizing the differences in relative wealth and poverty and other socio-economic factors; (3) reasonable deadlines for compliance with regulations should be agreed upon by all levels of government af-

fected by the regulations; (4) with respect to the application of fiscal sanctions, efforts should be made to distinguish between intent not to comply and management inefficiencies; and (5) States must be given greater flexibility in developing methods for reimbursing institutional providers."

The fourth item raised referred to Title XIX program administration performance measures. We recognize the rationale for performance criteria, both for penalties and for incentives for improved administration.

There was concern raised about possible inequities among States in applying criteria or measures, especially the potential financial impact. The feeling was, before you proceed with implementation of performance criteria or the measures, that you allow at least a 12 month period after you adopt the measures in order to have a data collection base and some background on which to really impose these penalties.

Fifth, fraud and abuse detection and evaluation. In short, what we are supporting is 90 percent FFP for State agency personnel involved in the identification, utilization review, evaluation, profiling, administrative actions taken, suspensions, et cetera, and/or civil restitution matters.

The reason -- abuse is greater than fraud. They coined the words in reverse. We feel it is 85 percent abuse and only 15 percent fraud. So if you really want to get at fraud and abuse in a broader sense, maybe give the 90 percent FFP. This FFP issue runs right along.

Facility survey and certification. Again, we know the 100 percent FFP expires September 1980, and we feel with the continued increase in long term care and other institutional services, that this FFP incentive should continue. In fact, we ought to quit projecting another expiration date and just allow it indefinitely.

Next item, rural health clinics. As we indicated to you last year, there is considerable difficulty, if you will, with the reimbursement policies and it just isn't reimbursement. In a clinic, as you know, we're paying for laboratory services for practitioners working out of the clinic, so it is a complicated type of reimbursement setting, and we offer, again, to work with you, hopefully to make some improvements in it.

And as a minimum, though, we are having great difficulty ascertaining what the clinic rates ought to be, even though they are determined by Medicare. We again plead with you to have HCFA issue a directive to the fiscal intermediaries, and whoever is working on the other side, to make these reports readily available to us because we don't know what the rate covers. Some of us do exclude certain types of services, such as drugs, dental care, et cetera.

Again, on eligibility matters, we feel that since the Federal law does not preclude spouse responsibility for institutional care, that you could possibly issue Federal regulations that would allow States the

flexibility to adopt the kinds of eligibility requirements and regulations they feel will meet the issue.

There is another matter we will be forwarding to you on medically needy persons where there is a problem in eligibility, where we really encourage institutionalization of the patient. We've got to figure a way to encourage having them stay in the community, and we'll be sending wording on that.

Another item relates to transfer of assets. We support proposed Federal regulations to preclude the transfer of real property of either an applicant or an MA eligible person at least two years prior to entitlement to MA benefits.

Another item on physician fees again, similar to last year. The Council does ask that States be allowed the option of establishing the basis, if you will, for physician and/or practitioner fee setting and reimbursement. I believe when you said you were thinking of going to fee schedules rather than usual and customary rate, which appears to be along the lines that will at least be helpful to us.

In short, we felt that this has been a very successful conference. We think that each year, the meetings seem to improve, and we feel one of the reasons is that you had a considerably larger number of State people on your panels. We don't want to say that is the key to success, but from the feedback we've had, it appears very good.

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